South Carolina Department of Insurance
1201 Main Street Suite 1000
Columbia, SC 29201

Mailing Address
P.O. Box 100105
Columbia, SC 29202

Utilization Review Renewal Additional Questions

Company Name _____
License Number _____

Renewal Year _____-_____

Contact Person Name _____
Contact Phone Number _____
Contact Email _____

1. Is there a physical office in the State of South Carolina?

   _____

2. List major owner(s) and percentage(s) of ownership if organization type is a corporation or partnership.
   a. _____
   b. _____
   c. _____

3. Provide state of incorporation if type of organization is a corporation (attach a copy of Certificate of Authority, Letter of Good Standing, and Article of Incorporation from State of Incorporation).
   a. State of Incorporation _____

4. List other locations. *Please attach on separate pages.*

5. List all partnerships or officers. *Please attach on separate pages.*

6. If any changes have not been sent to the Department, provide a listing of all reviewing personnel, by specific qualification/specialty. Include a total of all physicians, by specialty, which support and/or supervise reviewing personnel. *Please attach on separate pages.*

7. If any changes have not been sent to the Department, provide a copy of all materials designed to inform applicable patients of the requirements of the utilization plan, the rights of the patient under each contract, notification of adverse decision, appeal

procedures, and confidentiality of patient's medical records (Federal and State). *Please attach on separate pages.*

8. For which of the following categories does the applicant provide utilization review services? *Select as many as necessary.*

____ *Medical*
____ *Dental*
____ *Workers' Compensation*
____ *Physical Therapy*
____ *Chiropractic Services*
____ *Other (please specify)* _____

____ *Psychiatric (Behavioral Health)*
____ *Pharmacy*
____*Vision*
____ *Radiology*

I certify that I will comply with all applicable provisions of Title 38, Chapters 70 of the South Carolina Code of Laws. I certify all information submitted on this form and attachments is true and accurate. I understand that providing false information on this form may result in the revocation of the registration or imposition of administrative penalties for the Applicant under which this form is required.

Signature _____
Date _____
Name _____
Position _____

Subscribed and sworn to me before this _____ day of _____.

Notary Signature _____
My Commission Expires _____
County of _____
State of _____

(Notary Seal Affixed Here)