STATE OF NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE

SUPERINTENDENT OF INSURANCE
John G. Franchini - (505) 827-4299

DEPUTY SUPERINTENDENT
Robert Doucette - (505) 827-5832

INDEPENDENT REVIEW ORGANIZATION (IRO)
APPLICATION FORM

General Information -- If more room is needed, please attach additional sheets

Type of Application:

Original ____ Renewal ____ Update/Change to Original Application ____

Type of Entity:

Corporation ____ Partnership _____ Limited Liability Company ____ Other ____

If other, please explain _____

Name of Applicant:_____**FEIN**: _____

DBA Name: _____

_____

Primary Office Address (Do Not Use P.O. Box) **City** **State** **Zip**

_____

Mailing Address (if different**)** **City** **State** **Zip**

Office Telephone Number: ( )_____**Fax Number**: ( )_____

Primary Contact Person: _____

_____

Address **City** **State** **Zip**

Email Address: _____

Telephone Number: ( )_____**Fax Number**: ( ) _____

General Information (continued)

Primary Contact for Complaints: _____

_____

Address **City** **State** **Zip**

Email Address:_____ **Website:** _____

Telephone Number: ( )_____ **Toll-Free Number**_____ **Fax**: ( )_____

List all of the states in which Applicant is approved to conduct external reviews:

_____

Identify all accreditations held by the Applicant:

_____

_____

Has the applicant ever had an application denied by any state regulatory authority?

Yes ___ No ___

Explain, if "Yes" _

Has the applicant ever been the subject of regulatory action?

Yes ___ No ___

Explain, if "Yes" _____

_____

Has the applicant ever lost accreditation to perform independent reviews?

Yes ___ No ___

Explain, if "Yes" _____

_____

Organizational Documents and Relationships

Does the applicant own or control, or is it owned or controlled (in whole or in part) by, or does it have a contractual relationship with:

(a) an insurer
Yes ___ No ___

Explain, if "Yes" _____
_____

(b) health benefit plan
Yes ___ No ___

Explain, if "Yes" _____
_____

(c) trade association
Yes ___ No ___

Explain, if "Yes" _____
_____

(d) health care provider
Yes ___ No ___

Explain, if "Yes" _____
_____

Do any clinical reviewers employed by or contracted with the applicant have a history of being the subject of disciplinary action?
Yes ___ No ___

Explain, if "Yes" _____
_____

Provide a chart showing the internal structure of the Applicant's management and administrative staff.

Provide a detailed description of the procedures used by the applicant to ensure that the identity, financial information, and medical information of a claimant is not disclosed.

Provide a description of the applicant's written policies and procedures that govern all aspects of both the standard independent review and the expedited independent review process, including the procedures to ensure:

(a) that an independent review is conducted within the specified timeframe and that a required notice is provided in a timely matter;

(b) the selection of a qualified and impartial clinical reviewer to conduct the independent review and suitable matching of the review to a specific case; and

(c) that any individual employed by or under contract with the IRO adheres to all requirements

Provide a description of the applicant's quality assurance program.

Provide a description of the policies and procedures that the applicant will follow to ensure the independence of the IRO and the clinical reviewer.

CERTIFICATION

I,_____acting on behalf of Applicant, certify that Applicant has received accreditation by _____ to conduct independent external reviews.

I also state that I have read and understand the requirements for conducting external reviews for residents of New Mexico found at NMAC 13.10.17.19-23. Further, I have read the Memorandum of Understanding (MOU) between the NM Office of Superintendent of Insurance and IROs, and I am willing to execute the MOU and comply with the conditions set forth therein.

I have fully and truthfully completed this form to the best of my knowledge, information, and belief.

I have the authority and capacity to execute this certification on behalf of the Applicant.

I acknowledge that the NM Superintendent of Insurance has the sole discretion to add or remove the name of any IRO from the list of approved IROs, and the Superintendent's decision to not approve any organization or to remove any organization's approval is not subject to administrative appeal or judicial review.

_____

Applicant

_____

Signature

_____

Print or type full legal name

_____

Title

AFFIDAVIT

STATE OF)
) ss.
COUNTY OF)
_____)

Before me,_____, a notary public in and for the State of

_____

on this day personally appeared,_____known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged to me that (s)he executed the same for the purposes therein contained.

Given under this hand and seal of office this_____day of_____, 20_____.

_____ _____
Affix Notary Seal Here Notary Public

_____
My Commission Expires