

MEDICAL UTILIZATION REVIEW (MUR)
License Application

Section I. General Information

1. Name:
2. Principal address: (City, State, Zip)
3. Mailing address (if different): (City, State, Zip)
4. Address where records are kept:
5. Contact Person/Title, telephone number, fax, email address:
6. Federal ID#:
7. NAIC Company Code: (if applicable)
8. Does the company/organization hold any other licenses or registrations in Maine (If yes, Specify what type. Please list all used. Use separate sheet if necessary.)
9. D.B.A. (if applicable): (Please list all used. Use separate sheet if necessary.)
10. Type of organization: ☐ Individual ☐ Limited Liability Company
☐ Corporation ☐ Partnership ☐ Other (explain) _____

Foreign Corporations (Title 13-C M.R.S. § 1503), Foreign Limited Partnerships (Title 31 M.R.S. § 492), Limited Liability Companies (Title 31 M.R.S. § 712), or Limited Liability Partnerships (Title 31 M.R.S. § 852) must apply to the Maine Secretary of State for authority to do business in the State of Maine. ***Please attach proof of approval.***

Section II. Operations

1. A list of all states in which applicant is licensed to perform similar services, including current license numbers.

2. A list of all principal proprietors, partners, directors, officers and administrators. "Directors" refers to board of directors, executive committee or other governing board as applicable.
3. Provide number of applicant's employees in Maine and estimated number of employees nationally. If operations are conducted at more than one location in Maine, list locations and activities separately and give number of employees at each location.
4. A detailed description of the medical utilization review processes in place for each medical utilization review program offered by the applicant, including but not limited to:
 - A. Second opinion programs.
 - B. Hospital pre-admissions certification.
 - C. Pre-inpatient service eligibility determination.
 - D. Concurrent hospital review to determine appropriate length of stay.
 - E. Notification of covered persons and providers of utilization review decisions.
 - F. Other (explain).

Each of the above descriptions must include:

- A. The steps followed by the applicant's personnel in the performance of each type of review program.
 - B. The categories of health care personnel that perform medical utilization review for the applicant, and whether those persons are licensed in this State or any other state.
 - C. The qualifications and training received by personnel who are skilled lay persons performing medical utilization review for the applicant.
 - D. The data systems in place to support utilization review program activities and used to generate management reports to monitor and manage health care services.
 - E. The toll-free number or collect call phone line for access to review staff and how the line or lines are staffed to provide callers with adequate access to review staff.
5. A description of the processes used by the applicant to address beneficiary and provider requests for reconsideration, standard appeals, expedited appeals, and second level grievance reviews. The processes must be consistent with the requirements of Bureau of Insurance Rule Chapter 850.

6. A copy of all materials to be used by the applicant to inform beneficiaries of the requirements of the utilization review plans and the rights and responsibilities of the beneficiaries under the plan.
7. Copies of any policies and procedures the MUR entity has in place for use with their medical utilization review criteria.
8. A statement of whether the MUR entity has developed its own medical utilization review criteria, or whether it has contracted with any other entity to provide the MUR entity with review criteria. If the MUR contracts with another entity for criteria, a copy of the contract or license agreement, including the contract or agreement expiration date must be provided.
9. A description of the applicant's process for preserving the confidentiality of medical information used in the utilization review process.

Section III. Signature

By submitting this application, the applicant hereby certifies that all applicable state and federal laws to protect the confidentiality of medical information will be followed, and the applicant has read and will comply with the utilization review standards set forth in Title 24-A M.R.S.A. §2847, Chapter 34, Chapter 56-A and Bureau of Insurance Rule Chapter 850. The applicant further certifies that, in the event state and Federal timeframe requirements differ, it will utilize the shorter timeframe requirement, and that the applicant's internal policies are governed by and subordinate to all applicable state and federal requirements.

As the authorized representative of the utilization review entity, I hereby certify that all of the information submitted in this form and attachments is true and complete.

Signature of Authorized Person

Date

Type or Print Name

Title

