Annual Reporting of Utilization Review Activities
Missouri Department of Commerce and Insurance
Insurance Market Regulation Division
Life & Healthcare Section

(DUE March 1st)

COMPANY NAME:_____NAIC#_____

This form contains the items that are required to be in the annual report of Utilization Review Activities. This form and the certification letter referenced below represent all required items for this report. Annual Utilization Review Reports are for utilization activities conducted in the previous calendar year. Missouri Regulations and Statutes referenced in this filing are available at http://www.insurance.mo.gov/.

IF YOU ARE A HEALTH CARRIER PERFORMING UR FOR ANOTHER CARRIER, DO NOT FILE THIS REPORT FOR THAT HEALTH CARRIER

Part A. (check all that apply)

☐ **20 CSR 400-10.020(1)(A)** This report is being filed by a health carrier who is acting as a utilization review agent on their own behalf.

☐ **20 CSR 400-10.020(1)(B)** This report is being filed by a health carrier that has contracted with an outside utilization review organization or otherwise has delegated its utilization review activities. List or attach a list of all **companies, their addresses and UR agent license #'s** who are acting as a utilization review agent for this Health Carrier

Part B. (check all that apply)

Identify the types of utilization review activities your company has conducted:

☐ 1. Ambulatory Review ☐ 2. Concurrent Review

☐ 3. Prospective Review ☐ 4. Retrospective Review

☐ 5. Other types of Review Identify the Other types of Review _____

The company may provide additional statistical data that would better summarize its utilization review activities (i.e. case management, total number of reviews conducted, the number of each type of UR Activity conducted)

Part C.

1. Are there any material changes to your external (i.e. for consumers) grievance procedures since your last filing? ☐ Yes ☐ No

If so, please forward an updated copy of those external grievance procedures through SERFF and/or with a TD-1. [20 CSR 400-10.020(3): Only send if you have made any material changes since last filing]

2. Provide the DCI file number and date of the most recently approved policy and certificate(s)

_____

Pursuant to 376.1375 RSMo please disclose the following information. Please exclude ALL Medicare & Medicaid business.

3. Total number of grievance reviews conducted (3a) 1st Level #_____(3b) 2nd Level #_____

4. Disclose the outcome of those grievances:

Company's original decision upheld (4a) 1st Level #_____(4b) 2nd Level #_____
Company's original decision overturned (4c) 1st Level #_____(4d) 2nd Level #_____

5. Total number of expedited grievance reviews conducted #_____

Signature and title of company officer

_____

_____

Name, phone number and email address of person filing this report

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On your company letterhead, provide a signed certification of compliance reflecting the language found in 376.1369 RSMo and 376.1378 RSMo. Your Activity Report will be incomplete if these certifications are not provided.

Clear Form