



# LOUISIANA DEPARTMENT OF INSURANCE

JAMES J. DONELON

COMMISSIONER

## INSTRUCTIONS FOR INDEPENDENT REVIEW ORGANIZATION APPLICATION

### GENERAL INSTRUCTIONS

This packet is designed to assist the individual preparing this application in complying with the statutory and administrative requirements and to facilitate review of the application by the Louisiana Department of Insurance (LDI). Therefore, it is extremely important that all applicants comply fully with the instructions and requirements set forth in this packet. This package should be used as application for approval as an independent review organization pursuant to [La. R.S. 22:2440](#).

All communications should be directed to:

Louisiana Department of Insurance  
Company Licensing Division  
P.O. Box 94214  
Baton Rouge, LA 70804-9214  
Or  
1702 3<sup>rd</sup> St. Baton Rouge, LA 70802  
Phone: (225) 219-4318  
Fax: (225) 342-7401  
Email: [companyapps@ldi.la.gov](mailto:companyapps@ldi.la.gov)

While the LDI will be happy to assist you and answer any questions you may have, we ask that you thoroughly review all instructions and forms before contacting us.

- 1) The Louisiana Department of Insurance (LDI) accepts electronic submission of the application. The applicant should contact the LDI prior to submission to make arrangements for a secure portal for such a submission. Submission of sensitive or confidential information via standard email is not recommended. After submission of the application electronically, the payment of the fees must be submitted hard copy to the address above. All payments must be made payable to the Louisiana Department of Insurance.
- 2) If the application is submitted hard copy, all submittals in association with this application must reach the LDI via the United States Postal Service or a carrier with interstate business. Hand delivery is not acceptable and any information arriving in this manner will be returned without review. In addition, all correspondence must be sent to the attention of Company Licensing to assure prompt receipt and handling.
- 3) Submit only a fully completed application. Submittal of a partially completed application will cause processing delays and may result in disapproval.
- 4) Do not alter the forms contained in this packet. If you feel the requirements do not apply to your company, notify us. We will supply the proper form, if appropriate, and/or answer any questions you have about the forms.
- 5) All original items submitted become the property of the LDI and will not be returned.
- 6) All certified documents required in the application must be dated within ninety (90) days of submittal of the application. If an application is submitted hard copy rather than electronically, all certifications must be original.

- 7) All entries in the application forms must be typed or printed. Illegible entries or responses will be considered incomplete and may result in the disapproval of the application.
- 8) When designating a contact person for the application process, please remember that our staff will communicate only with this individual. The application process is considered confidential and will not be discussed with any person other than the named contact person. The applicant must notify the LDI in writing of any change in contact person.
- 9) The applicant must notify the LDI of any changes in the applicant or the information submitted in association with this application which occur while the application is under review. This includes changes in officers and directors; changes in address or domicile; and changes to the financial statements submitted in support of this application. Failure to notify the LDI of such changes may result in disapproval of the application.

## **REGISTRATION WITH THE LOUISIANA SECRETARY OF STATE**

The submission of this application to the Louisiana Department of Insurance does not in any way exempt a corporation or any other juridical entity from the requirements of registration with the Louisiana Secretary of State. It is the responsibility of the applicant to contact that Office and make whatever arrangements may be necessary. The address and telephone number are:

Louisiana Secretary of State  
Corporations Division  
P.O. Box 94215  
Baton Rouge, LA 70804-9215  
(225) 925-4704  
[www.sos.louisiana.gov](http://www.sos.louisiana.gov)

## **INSTRUCTIONS FOR ATTESTATION PAGE**

This application is designed to be an authentic act under Louisiana law. As such, the attestation page requires the signature of an officer which must be witnessed by two persons AND executed before a notary.

If the application is filed in the name of an individual, the individual must sign the application. If the application is filed for other than a natural person (individual), the application must be signed by an executive officer or other comparable responsible person (officer, director, partner, managing member or sole proprietor).

## **COMMON QUESTIONS**

The following are some of the most commonly asked questions regarding the application package and process.

**Q: Where can I find the laws and regulations governing independent review organizations in Louisiana?**

**A: The laws governing Independent review organizations can be found in Chapter 18 of Title 22 of the Louisiana Revised Statutes ([La. R.S. 22:2391](#) et seq.).**

**Q: What is the time frame for the review of an application?**

**A: This Department reviews all applications as soon after submittal as possible. The review process can be expected to take from sixty (60) to ninety (90) days from receipt of a complete application. Please take this time frame into account when considering deadlines and operation schedules for the applicant.**

**Q: Can the forms in the application packet be recreated on a word processor for completion by the applicant?**

**A: No. The forms in this packet are designed for ease of recognition by our staff and, in many cases, in strict compliance with statutory wording requirements. Therefore, any changes in the format or wording of the forms will cause delays in the review and may lead to the disapproval of the application. The forms are made available on our web site in a format that allows for entry of information directly onto the form.**

**Q: Can we meet with the Department for a preliminary review of our application prior to submission?**

**A: Yes. Our staff will be happy to meet with representatives of the applicant to review the application before it is actually submitted. It should be noted, however, that this courtesy review is to help assure completeness only and our Division will not issue a preliminary approval or disapproval of the application prior to submission. You may make an appointment for preliminary review by contacting the Company Licensing Division of the Louisiana Department of Insurance. Preliminary reviews will be performed only with an appointment.**



LOUISIANA DEPARTMENT OF INSURANCE

JAMES J. DONELON

COMMISSIONER

**APPLICATION TO ACT AS A  
INDEPENDENT REVIEW ORGANIZATION  
IN THE STATE OF LOUISIANA**

GENERAL INFORMATION (Type or Print)	
APPLICANT NAME: _____	
TRADE NAME: _____	
FEI OR SOCIAL SECURITY NO.: _____ DOMICILE: _____	
CONTACT*: _____ CONTACT TITLE: _____	
CONTACT ADDRESS: _____ _____ _____	
PHONE: _____ FACSIMILE: _____	
E-MAIL: _____	
* This Office will only communicate with the named contact person.	
FEES	
Initial Application	\$ 500.00

## SECTION 2 - INTERROGATORIES

All of the following questions must be answered for every applicant. ATTACH A FULL EXPLANATION FOR ANY "YES" ANSWERS

<p>1) Has the applicant ever had an application denied by any state or federal regulatory authority? (If yes, provide details including the type of application, the identity of the authority which issued the denial, the reasons for the denial and an explanation of any subsequent events.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>2) Has the applicant or any entity which is affiliated or under the same general management, interlocking directorate or ownership as the applicant ever had a Certificate of Authority or license suspended or revoked by any regulatory authority? (If yes, provide details including the type of action, the identity of the authority that took the action, the reasons for the action, a copy of the order or other such notice of the action and an explanation of any subsequent events.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>3) Has the applicant ever been subject to any regulatory action including cease and desist orders, fines, consent agreements or similar actions? (If yes, provide details including the type of action, the identity of the authority that took the action, the reasons for the action, a copy of the order or other such notice of the action and an explanation of any subsequent events.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>4) Has the applicant ever been placed into any type of regulatory supervision or rehabilitation by any regulatory authority? ( If yes, provide details including the type of action, the identity of the authority that took the action, the reasons for the action, a copy of the order or other such notice of the action , an explanation of any subsequent events and an explanation of the current status.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>5) Is the applicant currently involved in any dispute or controversy with any regulatory authority?</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>6) Has the applicant ever been the subject of bankruptcy or liquidation proceedings? (If yes, provide the jurisdiction of the proceedings, the docket number, the current status and the date of final disposition.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>7) Is the applicant currently a defendant or the subject in any legal action alleging fraud, dishonesty or breach of trust on the part of the applicant or its officers, directors, trustees or members? (If yes, supply a statement giving the jurisdiction of the case, a summary of the allegations, the case style (name) and a summary of the current status of the case.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>8) Has the applicant or any person who is presently an officer, director or owner of 10 percent or more of the applicant ever been convicted of or pleaded guilty or nolo contendere to, or found liable of indictment or bill of information, in any jurisdiction, charging a felony or misdemeanor other than minor traffic violations?</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>9) Within the last five years, has the applicant changed its name?</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>10) Within the last five years, has the applicant undergone a change in domicile? (Changes of domicile address within the same state need not be included.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>11) Within the last five years, has the applicant merged or consolidated with any other entity?</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>12) Within the last five years, has the applicant undergone a change in ownership (direct or indirect) of 10 percent or more? (If yes, provide a full explanation of the change in ownership and an organizational/ownership chart which clearly shows the ownership of the licensee both before and after the transaction.)</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

## SECTION 2 – INTERROGATORIES - Continued

<b>13) Is the applicant presently negotiating or inviting negotiations or acting as party to a counter-letter which would result in a merger or consolidation with any other entity or which would result in a change of ownership of 10 percent or more of the applicant?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>14) Does the applicant contemplate a change in management or any transaction which would normally result in a change of management within the foreseeable future?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>15) Is the applicant owned, operated or controlled, directly or indirectly, by any other state or province, district, territory or nation or any governmental subdivision or agency?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>16) Is the applicant or any entity which is affiliated or under the same general management, interlocking directorate or ownership as the applicant currently licensed in any capacity by the Louisiana Department of Insurance? (If yes, provide the full name of the affiliated entity and the type of license(s) held in Louisiana.)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>17) Has the applicant or any entity which is affiliated or under the same general management, interlocking directorate or ownership as the applicant operated in any capacity in Louisiana for which it would be required to be licensed by the Louisiana Department of Insurance without having first obtained the necessary license?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>18) Is the applicant currently undergoing an examination or audit (whether routine, targeted or otherwise) being conducted by any state or federal regulatory authority?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>19) Is the applicant part of an insurance holding company group? (If yes, provide the holding company group code assigned by the NAIC _____.)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>20) Is the applicant or its parent corporation a publicly traded company? (If yes, attach a copy of the most recent 10K or equivalent filing.)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>21) Does the regulatory authority governing the applicant in the state or country of domicile have any statutes or regulations that might prohibit or restrict in any way the disclosure of information concerning the applicant to the Louisiana Department of Insurance?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>22) Does the applicant own or control a health insurance issuer, health benefit plan, a national, state or local trade association of health benefit plans, or a national, state, or local trade association of health care providers</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>23) Is the applicant accredited by URAC? If Yes, provide a copy of the certificate or other document verifying this accreditation.</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>24) Has any person who will be performing peer review for the applicant ever been the subject of or currently have pending any disciplinary actions including loss of staff privileges or participation restriction by any hospital, governmental agency or unit which would raise a substantial question as to the individual's physical, mental or professional competence or moral character?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**SECTION 3 - LIST OF MANAGEMENT AND OWNERS**

Below give the full legal name (no initials), resident address, position with the applicant and the percentage of ownership (if applicable) of all natural persons responsible for the conduct of affairs of the applicant. This list should include all officers, all directors, all partners (in the case of a partnership), all trustees, all executive committee members and every natural person owning, directly or indirectly, 10 percent or more of the applicant and any other natural person who exercises control or influence over the affairs of the applicant.

<b>NAME:</b>			
<b>STREET:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>POSITION:</b>		<b>OWNERSHIP %:</b>	
<b>NAME:</b>			
<b>STREET:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>POSITION:</b>		<b>OWNERSHIP %:</b>	
<b>NAME:</b>			
<b>STREET:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>POSITION:</b>		<b>OWNERSHIP %:</b>	
<b>NAME:</b>			
<b>STREET:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>POSITION:</b>		<b>OWNERSHIP %:</b>	
<b>NAME:</b>			
<b>STREET:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>POSITION:</b>		<b>OWNERSHIP %:</b>	
<b>NAME:</b>			
<b>STREET:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>POSITION:</b>		<b>OWNERSHIP %:</b>	
<b>NAME:</b>			
<b>STREET:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>POSITION:</b>		<b>OWNERSHIP %:</b>	

## SECTION 4 - SPECIALTIES

Indicate all of the specialties for which the applicant has available peer review personnel.

Aerospace Medicine

Allergy and Immunology

Anesthesiology

Clinical Biochemical Genetics

Clinical Cytogenetics

Clinical Genetics (MD)

Colon and Rectal Surgery

Dermatology

Diagnostic Radiology

Emergency Medicine

Family Medicine

Internal Medicine

Interventional Radiology and  
Diagnostic

Long-Term Care

Medical Genetics and Genomics

Medical Physics

Neurological Surgery

Neurology

Neurology / Child Neurology

Nuclear Medicine

Obstetrics and Gynecology

Occupational Medicine

Ophthalmology

Orthopaedic Surgery

Otolaryngology

Otolaryngology

Pathology

Pathology - Anatomic

Pathology - Clinical

Pediatrics

Physical Medicine and  
Rehabilitation

Plastic Surgery

Preventative Medicine

Psychiatry

Psychiatry and Neurology

Pulmonary

Public Health and General  
Preventative Medicine

Radiation Oncology

Radiology

Surgery

Thoracic and Cardiac Surgery

Urology

Vascular Surgery



## **SECTION 5 - EXHIBITS**

**EXHIBIT A - Copy of the Articles of Incorporation, Articles of Association, partnership agreement or other such organizational documents and all amendments thereto of the applicant certified by the proper domiciliary official. The certification must be dated within ninety (90) days of submission.**

**EXHIBIT B - Copy of the by-laws, operating agreement, rules, regulations or similar document of the applicant certified as true and correct by the secretary of the applicant. The certification must be dated within ninety (90) days of submission.**

**EXHIBIT C - Trade name certificate issued by the Secretary of State of Louisiana confirming registration of any trade name with that Office. This item must be supplied by any applicant utilizing a trade name in Louisiana.**

**EXHIBIT D – Completed biographical affidavits for all persons responsible for the conduct of affairs of the applicant. This should include all officers, all directors, all partners (in the case of a partnership), all trustees, all executive committee members and all person(s) owning, directly or indirectly, 10 percent or more of the applicant and any other person who exercises control or influence over the affairs of the applicant. Only the most recent version of the affidavit adopted by the National Association of Insurance Commissioners is acceptable and all affidavits must be executed no more than 180 days prior to submission. This form can be obtained from the NAIC web site ([http://naic.org/documents/industry\\_ucaa\\_form11.pdf](http://naic.org/documents/industry_ucaa_form11.pdf)).**

**EXHIBIT E – Copy of the procedures manual of the applicant which meets the statutory requirements for making performing external independent reviews. Required only from applicants which are not accredited by URAC.**

**EXHIBIT F - A detailed description of the corporate organizational/ownership structure of the applicant, its parent company and all affiliates. This description should include a chart showing the ownership percentages for any persons owning 10 percent or more of the applicant and all affiliated entities up to and including the ultimate controlling person. The chart must include the state of domicile and the Federal Employer Identification Number (FEIN) for each person. A sample chart is available at <https://www.ldi.la.gov/docs/default-source/documents/licensing/companies/sample-ownership-chart.pdf?sfvrsn=0> If there is no person who owns, directly or indirectly, 10 percent or more of the applicant then you must provide a statement to that effect in lieu of this exhibit.**

## SECTION 6 – ADDRESSES AND CONTACT INFORMATION

<b>DOMICILE ADDRESS: Below give the domiciliary (registered office) address of the applicant.</b>		
Address:		
City:	State:	Zip:

<b>MAILING ADDRESS: Below give the mailing address of the applicant.</b>		
Address:		
City:	State:	Zip:

<b>ADMINISTRATIVE OFFICE ADDRESS: Below give the physical address of the main administrative office of the applicant.</b>		
Address:		
City:	State:	Zip:

<b>REVIEW ASSIGNMENT CONTACT: Below give the name, address, telephone number and e-mail address of the person to whom notice of assignment of external review requests should be sent.</b>		
Name:		
Address:		
City:	State:	Zip:
Phone Number:	Email Address:	

<b>TOLL FREE NUMBER: Provide the toll-free telephone number designated to receive information related to external reviews on a twenty-four-hour-a-day, seven-day-a-week basis.</b>

## ATTESTATION

STATE OF \_\_\_\_\_

COUNTY OR PARISH OF \_\_\_\_\_

BEFORE ME, the undersigned authority, personally appeared \_\_\_\_\_

and \_\_\_\_\_ who, after being duly sworn, did depose and say that all information contained in

this application and all attachments thereto is, to the best of his/her knowledge, true, complete and correct and that the

independent review program of the applicant complies with applicable state and federal laws .

The undersigned do further attest and affirm all of the following;

- 1) The applicant does not own or control and is not a subsidiary of a health insurance issuer, health benefit plan, a national, state or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.
- 2) The applicant shall not accept assignment of any external review case in which it or any clinical peer assigned to conduct the external review has a material, professional, familial or financial conflict of interest with the health insurance issuer, covered person, any officer, director or management employee of the health insurance issuer, the health care provider (including the medical group or independent practice association of the provider) the facility at which the recommended health care service or treatment would be provided nor the developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person.
- 3) The applicant agrees to maintain and provide to the Commissioner of Insurance of Louisiana the information and reports required pursuant to La. R.S. 22:2443.

# ATTESTATION

- 4) No person any person who will be performing peer review for the applicant has ever been the subject of or currently have pending any disciplinary actions including loss of staff privileges or participation restriction by any hospital, governmental agency or unit which would raise a substantial question as to the individual's physical, mental or professional competence or moral character.

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Printed Name and Title of Authorized Representative

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Authorized Representative of Applicant

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Printed Name and Title of Authorized Representative

SWORN TO and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary Public's Signature

\_\_\_\_\_  
Notary Public's Printed Name

My Commission Expires \_\_\_\_\_