Submit two copies of the completed, signed application and the complete Utilization Review (UR) Plan in compact discs or flash drives in word-searchable PDF format to: Division of Workers' Compensation, Attn: Medical Unit: Utilization Review Plan Approval, P.O. Box 71010, Oakland, CA 94612.

1. UR Plan Information

Name of UR Plan Applicant:

Address:

City:

State: Zip Code:

Telephone: Fax:

E-mail:

Type of Entity Filing:

2. UR Plan Contact Person Information

Name:

Title:

Address:

City:

State: Zip Code:

Telephone: Fax:

E-mail:

3. Medical Director Information

Name:

Address:

City:

State: Zip Code:

Telephone: Fax:

E-mail:

CA License No.: NPI:

Board Certified Specialty (if any):

4. URAC Accreditation

Accreditation Status:

Original accreditation date:

Most recent accreditation date: Expiration Date:

Comments:

5. UR Plan Client and Vendor Information

List all entities that utilize or contract for UR Plan services. Use additional pages if necessary.

Does the UR Plan delegate any UR functions? ○ Yes ○ No

If yes, indicate to whom and and which function for each delegation. Use additional pages if necessary.

Signature of authorized individual: "I, the undersigned Medical Director of the UR Plan Applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct."

Name of Medical Director:

Date Signature: