NEW YORK STATE DEPARTMENT OF HEALTH
Office of Managed Care
Bureau of Managed Care Certification and Surveillance

Utilization Review Agent Registration Application and Attestation

Complete and sign this form. Submit with completed Utilization Review Registration Application Summary/Checklist (DOH-4291B), unless re-registrant attests below that there are no changes to previous application.

Check one: ☐ New application ☐ Re-registration

Name of Applicant:		
Street Address:		
City:	State:	Zip:
Name of Chief Executive Officer Last: First: Middle Initial:		
Title:		
Street Address:		
City:	State:	Zip:
Phone: ( ) -	Fax: ( ) -	
TAX STATUS ☐ Privately Held ☐ Not for Profit ☐ Publicly Traded-for Profit		
Federal Employer ID Number:		

Attestation:

I, _____ (Chief Executive Officer) subscribe and affirm as true, under penalty of perjury,

- ☐ the information included in this Article 49 application and reported to the New York State Department of Health.
- ☐ there are no changes to the Article 49 application as reported to the New York State Department of Health on _____. (date)
- ☐ the information included in this Article 49 renewal application and reported to the New York State Department of Health as amending the Article 49 application reported to the New York State Department of Health on _____. (date)

Signature:	**Date:**