

## Certification of Independence and Qualifications of the Reviewer

### Independent Review Information

IRO Case Number \_\_\_\_\_ Patient Name \_\_\_\_\_

1. As of the date of this review, I have an unrestricted license, certification, or registration in the following state(s) [list state(s), license number(s) and expiration date(s)].

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There are no sanctions or revocations of my license, certification, or registration by any state licensing agency in the United States or the U.S. Department of Health and Human Services.

2. I am currently in active practice in [list state(s)].
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3. I had no previous knowledge or participation of this case prior to it being assigned to me for review.
  4. I have no disqualifying associations, business, or personal relationship, with any of the involved parties in this case (physicians or any other parties who have provided care or advice regarding this case, URA, payor).
  5. I do not have admitting privileges or an ownership interest in the health care facilities where care was provided or is recommended to be provided. I am not a member of the board or advisor to the board of directors or any of the officers at any of the facilities.
  6. I do not have a contract with or an ownership interest in the utilization review agent, the insurer, health maintenance organization, other managed care entity, payor, or any other party to this case. I am not a member of the board or advisor to the board of directors or an officer for any of the above referenced entities.
  7. I have performed this review without bias for or against the utilization review agent, the insurer, health maintenance organization, other managed care entity, payor, or any other party to this case.

### Certification

As the reviewer of this independent review case, I do hereby certify that all the above statements are, to the best of my knowledge and belief, true and correct to the extent they are applicable to this case and my relationships.

I understand that submission of a false certification may subject me to penalty under applicable law.

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Print or Type Legal Name of Reviewer

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Signature of Reviewer

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Date

## Questions

If you have questions or require assistance regarding completion of this form, please call 512-676-6400, select Option 2.

## Your rights

You can request information we have about you by emailing [OpenRecords@tdi.texas.gov](mailto:OpenRecords@tdi.texas.gov) or writing to: Public Information Coordinator, Texas Department of Insurance, P.O. Box 12030 (mail code GC-ORO) Austin, Texas 78711-2030. You also have the right to ask that we fix information we have about you that is wrong. To ask for a correction, send (1) your name, mailing address, and your phone number, (2) details about what needs to be fixed, and (3) the reason or proof showing why the information is wrong. Send this by email to [RecordCorrections@tdi.texas.gov](mailto:RecordCorrections@tdi.texas.gov) or by mail to: Record Correction Request, Texas Department of Insurance, P.O. Box 12030 (mail code CO-AAL-CC), Austin, Texas 78711-2030.