STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Application to be a Qualified Vendor of Behavioral Health Clinical Review Criteria

Company Name _____

Company Address _____

_____

_____

Contact Name _____

Contact phone number _____

Contact e-mail address _____

Please list companies licensed to write health insurance in Connecticut that currently utilize your behavioral health clinical review criteria:

_____

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THE FOLLOWING CERTIFICATION MUST BE COMPLETED WHEN APPLYING TO BE A QUALIFIED VENDOR FOR BEHAVIORAL HEALTH CLINCIAL REVIEW CRITERIA

I, _____, _____
(PRINTED NAME) (TITLE)

of _____, hereby acknowledge that
(COMPANY)

_____, meets the requirements to become a
(COMPANY)

qualified vendor for behavioral health clinical review criteria in accordance with Conn. Gen. Stat.§§38a-591c and as outlined in Bulletin HC-105.

_____
(SIGNATURE)

_____
(DATE)