



Utilization Review Vendor Questionnaire

Please return this form electronically after completion.

TPA Name: _____

Address: _____

Website: _____

Utilization Review Form

Utilization Review Model	Free Standing	TPA Owned	Leased
Licensed			

Name and address (if different from above) _____

Medical Contact _____ Title _____

Telephone _____ E-Mail _____

Does TPA/UR firm currently have cases with TMHCC Yes No

If "No", list prospective case: _____

How many employees live does the TPA/UR firm service? _____

Number of U.R. Nurses on staff? _____

Do you have a full-time Medical Director or advisor? _____

Is there a Medical Director or are Physician Consultants available to the non-physicians reviewers? Yes No

Are you URAC accredited? Yes No

If "No", what accreditation does your firm have? _____

What services does the UR firm offer?

Precertification Yes No

Concurrent Review Discharge Yes No

Planning Yes No

Are services packaged or separate? Packaged Separate

Do you screen for "high risk" pregnancy Yes No

Do you certify for psych/substance abuse Yes No

UR Level? OR Yes No

Case Management Level Yes No

Do you offer Retrospective review? Yes No

Do you offer Prospective review? Yes No

Is LCM services provided in-house / subcontracted? _____

Name/Address of outside vendor, if applicable _____

Does the system used for precert interact with TPA claims system? Yes No

Who takes the initial intake call for precert? UR Nurse Other _____

Are potentially catastrophic cases identified via the system? _____

If not, please explain process _____

Will your firm program TMHCC's Trigger Diagnosis List into your system? Yes No

Is the TPA/UR firm willing to notify and disclose information to TMHCC Risk Management within two business days of identifying catastrophic cases? _____

How will the vendor / TPA refer cases to TMHCC Risk Management? _____

As cases are identified Yes No On a weekly report? Yes No

Completed by _____

Date _____