Appendix D – Model Health Carrier External Review Annual Report Form

Arkansas Insurance Department
Health Carrier External Review Annual Report Form

External Review Annual Summary for 20	____.	
Due on [insert date] for previous calendar year.		
Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.		
1. Health carrier name:	______________________	Filing Date: ______________
2. Health carrier address:	______________________	
City, State, ZIP:	______________________	
3. Health carrier Web site:	______________________	
4. Name, email address, phone and fax number of the person completing this form:		
______________________		
______________________		
5. Total number of external review requests received from [insert state insurance department name] during the reporting period:	________	
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:	________	

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