SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION
DIVISION OF LABOR AND MANAGEMENT
123 W. Missouri Ave. Pierre, South Dakota 57501
Tel: 605.773.3681 Fax: 605.773.4211 dlr.sd.gov

SELF-INSURED EMPLOYER'S PLAN FOR MANAGED CARE

Name of Applicant: _____

Use this form to comply with SDCL 62-5-21 and ARSD Chapter47:03:04. Answer completely the following questions about your managed care plan. If more space is needed, use additional pages (identify your response with the question number). Any supporting documents should be attached to this application. If you have any questions about the information requested, please call 605.773.3681.

CONTACT PERSON Name: _____

Address: _____

Phone number: (___) ____-_____ Alternate Phone number: (____) ____-_____

ADMINISTRATOR

Day-to-day administrator of the managed care plan

Name: _____ Title: _____

Credentials: _____

MANAGED CARE PLAN

1. How will you provide employees prompt and convenient access to health care services as required by ARSD 47:03:04:04? Specifically, how will you make sure employees receive prompt treatment when they request treatment from the plan? What are your procedures for referring an employee to an outside medical practitioner when services are unavailable or are not reasonably accessible within the plan? How will you handle emergency treatment?

2. How will you monitor the treatment and medical progress of the employee, and make sure that the employee is following the treatment plan?

3. How will you develop a plan for promptly returning an employee to work?

4. What are your plan's internal dispute resolution procedures, including methods to promptly resolve complaints by employees and medical practitioners? How will you notify individuals of decisions made by your plan and the procedures for disputing those decisions.

The applicant, by its authorized corporate officer:

- Acknowledges receiving a copy of the ARSD chapter 47:03:04, the rules for managed care plans for workers' compensation;
- Authorizes the department to audit or investigate the accuracy of any statement made in this application and related documents;
- Agrees to assist the department in conducting the audit or investigation; and
- Agrees to allow the department access to its place of business and to information and record requested by the department.

The applicant understands and agrees that if a material fact in this application or related documents has been misrepresented or if the managed care plan no longer meets the requirements of the law and administrative rules, the department may deny or may suspend or revoke the certification of the managed care plan under ARSD 47:03:04:11.

_____

Applicant Name (Print)

_____

Signature of Authorized CorporateOfficer *Date*