

COMMONWEALTH OF KENTUCKY  
DEPARTMENT OF INSURANCE  
DIVISION OF HEALTH INSURANCE POLICY AND MANAGED CARE

MEDICAL DIRECTOR REPORT FORM

In accordance with 806 KAR 17:230, an insurer shall submit the information specified on this form, as well as a biographical resume of the Medical Director and Alternative Medical Director to the KY Department of Insurance, Division of Health Insurance Policy and Managed Care, P.O. Box 517, Frankfort, KY 40602. This format shall be used to report information initially and to report any subsequent change in the information within thirty (30) days of the change.

**Medical Director**

Name \_\_\_\_\_

State(s) of Medical Licensure \_\_\_\_\_

KY Medical Licensure Number \_\_\_\_\_

Residence Address  
\_\_\_\_\_  
\_\_\_\_\_

Business Address  
\_\_\_\_\_  
\_\_\_\_\_

Business Telephone Number \_\_\_\_\_

**Alternative Medical Director**

Name \_\_\_\_\_

State(s) of Medical Licensure \_\_\_\_\_

Medical Licensure Number \_\_\_\_\_

Residence Address  
\_\_\_\_\_  
\_\_\_\_\_

Business Address  
\_\_\_\_\_  
\_\_\_\_\_

Business Telephone Number \_\_\_\_\_