

**KENTUCKY DEPARTMENT OF INSURANCE  
DIVISION OF HEALTH, LIFE INSURANCE AND MANAGED CARE**

**MEDICAL DIRECTOR REPORT FORM**

In accordance with 806 KAR 17:230 and 806 KAR 17:280, section 4, an insurer/private review agent 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, via email to [DOI.UtilizationReview@ky.gov](mailto:DOI.UtilizationReview@ky.gov). 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 \_\_\_\_\_

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

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

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

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