Department of Consumer and Business Services
Insurance Division – 4
P.O. Box 14480, Salem, Oregon 97309-0405
350 Winter St. NE, Salem, Oregon
Phone: 503-947-7982, Fax: 503-378-4351
Email: dcbs.insmail@oregon.gov
insurance.oregon.gov

Retainer Medical Practice Renewal Application

1. Name of applicant: ______________________

   Domicile: ______________ Date established: ________ FEIN: ________

2. Assumed business name: ______________________

3. Other identities (if applicable): ______________________

4. Mailing address line 1: ______________________

   Address line 2: ______________________

   City: ______________ State: ________ ZIP: ________

   Phone: - - Fax: - - Email: ______________

5. Physical address line 1: ______________________

   Address line 2: ______________________

   City: ______________ State: ________ ZIP: ________

   Phone: - - Fax: - - Email: ______________

6. Administrative contact person: ______________________

   Mailing address line 1: ______________________

   Address line 2: ______________________

   City: ______________ State: ________ ZIP: ________

   Phone: - - Fax: - - Email: ______________

7. Registered office and agent for legal services in Oregon:

   ____
   (Name of registered agent at registered office)

   ____
   (Address of registered office, including street, number, city, state, and ZIP)

8. List the physical and mailing addresses, phone numbers, fax numbers, email addresses, and website addresses for each location providing retainer medical services, if different from above:

   ____

   ____

9. List the names and Oregon license numbers of all providers delivering services through the retainer medical practice:

   ____

   ____

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10. Has the license of any medical retainer provider been suspended, revoked, or not renewed?

☐ Yes ☐ No

If yes, please explain: ______________________________

11. During the past year has the retainer medical practice received a license or registration to transact business as a retainer medical practice in another jurisdiction?

☐ Yes ☐ No

If yes, identify jurisdiction and agency: ______________________________

12. During the past year, has the retainer medical practice's license or registration in another jurisdiction been suspended, revoked, or not renewed?

☐ Yes ☐ No

If yes, provide contact information for the agency taking action, action taken, date of action, and the reason for the action: ______________________________

____

13. During the past year, has the applicant filed for bankruptcy?

☐ Yes ☐ No

If yes, provide details:

____

____

Also provide reasons why the bankruptcy should not be used by the director as evidence that the applicant is not financially responsible and form the basis for a denial of recertification:

____

____

14. Has the applicant, a person with control of the applicant, or a provider who provides services on behalf of the applicant been charged with a felony or with a misdemeanor involving dishonesty?

☐ Yes ☐ No

If yes, explain:

____

____

15. Total number of people under a retainer medical agreement in prior calendar year: ______________

16. Total number of people under a retainer medical agreement that voluntarily terminated the retainer medical practice agreement during the prior calendar year: ______________

17. Total number of people under a retainer medical agreement whom the retainer medical practice terminated the agreement: ______________

(For each patient, explain on a separate sheet why the agreements terminated.)

18. Total number of applicants declined by the retainer medical practice: ______________

(For each applicant, explain on a separate sheet the reason for denial.)

APPLICANTS ATTESTATIONS

1. Providers delivering services under the retainer medical agreement are licensed or certified under ORS chapters 677, 678, 684, or 685 and the services provided will be limited to primary care services allowed within the scope of such licenses or certifications. [OAR 836-200-0305(1)(c)(A)(i)]

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2. The applicant is not and has never been authorized in this or any other state to transact insurance or act as an insurer, managed care organization, health care services contractor, or similar entity. [OAR 836-200-0305(1)(c)(A)(ii)]
3. The applicant is not controlled by any person authorized in this or any other state to transact insurance or act as an insurer, managed care organization, health care services contractor, or similar entity. [OAR 836-200-0305(1)(c)(A)(iii)]
4. The applicant continues to structure the retainer medical practice to ensure that all services promised under the retainer medical agreement are within the capacity of the practice to provide in a timely manner. [OAR 836-200-0305(1)(c)(A)(iv)]
5. The applicant continues to be financially responsible. [OAR 836-200-0305(1)(c)(A)(v)]
6. Marketing materials, websites and retainer medical agreements contain, on the first content page, the required disclosures. [OAR 836-200-0315]
7. The applicant does not discriminate based on race, religion, gender, sexual identity, sexual preference, or health status. [OAR 836-200-0305(1)(c)(A)(viii)]
8. The applicant is authorized to conduct business in the state of Oregon and has complied with all registration requirements of this state. [OAR 836-200-0305(1)(c)(A)(ix)]
9. The information provided in the renewal application and all supplemental and additional information is true and complete, and the applicant will submit to the jurisdiction of the courts of the State of Oregon. [OAR 836-200-0305(1)(c)(A)(x)]

I, (name) ______________________________, make the foregoing attestations on behalf of the retainer medical practice. I am authorized to make such attestations by virtue of the position I hold as (position title) ______________________________ with respect to the applicant.

______________________________ ______________________________
Signature Title

We, ______________________________, ______________________________
Name Title

and ______________________________, ______________________________
Name Title

certify that we are officers with responsibility for the operation of the organization named in the foregoing application, that we know the contents thereof, and each of the statements and answers made is true and complete to the best of our knowledge and belief. Further, the organization submits to the jurisdiction of any court of competent jurisdiction in Oregon for the adjudication of any issues arising out of its retainer medical practice, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal.

Date: ____________________ Signature: ______________________________

Title: ______________________________

Date: ____________________ Signature: ______________________________

Title: ______________________________