

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



CONFLICT OF INTEREST STATEMENT

(DISTRICT OF COLUMBIA, OFFICE OF HEALTH CARE OMBUDSMAN AND BILL OF RIGHTS)

THIS IS TO CERTIFY THAT _____ ,
(NAME OF INDEPENDENT REVIEW ORGANIZATION)

ITS STAFF, AND ITS PROFESSIONAL AND MEDICAL REVIEWERS (**DOES NOT**)

(**DOES**) HAVE MATERIAL, PROFESSIONAL, FAMILIAL OR FINANCIAL

AFFILIATION WITH:

(Insert name of health benefits plan, provider, provider facility, or health benefits plan member or other entity involved named in this appeal)

Signature of Authorized Agent:

Signature

Name

Title

Date: _____

(AFTER SIGNATURE, PLEASE RETURN TO THE OFFICE OF HEALTH CARE OMBUDSMAN AND BILL OF RIGHTS, DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE, 899 NORTH CAPITOL STREET, N.E., 6TH FLOOR, WASHINGTON, D.C. 20002)