



NORTH DAKOTA

Insurance & Securities

PRIOR AUTHORIZATION DATA CALL

Annual Data Call Pursuant to N.D.C.C. § 26.1-36.12-17

Reporting Period: Calendar Year 2025

STATUTORY AUTHORITY

N.D.C.C. § 26.1-36.12-17 requires each prior authorization review organization to report to the Insurance Commissioner by September 1 of each year

The report must be available online and in a form specified by the Commissioner. This workbook constitutes the form specified by the Commissioner for collection of the data elements required under subsection 3 of § 26.1-36.12-17.

INSTRUCTIONS

1. Complete the "Entity Information" section on the Data Call tab with the reporting organization's identifying information.
2. Enter all requested data in the yellow-highlighted input cells on the Data Call tab.
3. Percentage fields (Section E) will auto-calculate based on your numeric entries.
4. A validation check section at the bottom will flag any internal inconsistencies.
5. Submit the completed workbook to the Department by September 1.
6. Direct questions to the Company Life & Health Division.

KEY DEFINITIONS (N.D.C.C. § 26.1-36.12-01)

"Adverse"	A decision by a prior authorization review organization relating to an admission, extension of stay, or health care service that is
"Authorization"	A determination that a health care service has been reviewed and satisfies the organization's requirements for medical necessity
"Prior authorization"	The review conducted before the delivery of a health care service to evaluate the necessity, appropriateness, and efficacy of health
"Prior authorization"	A person that performs prior authorization for an employer, insurer, PPO, HMO, or any other person that provides or administers

Prior Authorization Review Organization Name (Legal Name)

NAIC Company Code (if applicable)

FEIN

Mailing Address

City, State, ZIP

Contact Person (Name & Title)

Contact Phone Number

Contact Email Address

Website URL (where report is publicly available per § 26.1-36.12-17(2))

Reporting Period (Calendar Year)

MedImpact Healthcare Systems, Inc.

2025

Item	Data Element	Statutory Reference	Value	
3(a)	Total number of prior authorization requests received	§ 26.1-36.12-17(3)(a)	0	
3(b)	Number of prior authorization requests for which an authorization was issued	§ 26.1-36.12-17(3)(b)	0	
3(c)	Number of prior authorization requests for which an adverse determination was issued	§ 26.1-36.12-17(3)(c)	0	
3(d)	Number of adverse determinations reversed on appeal	§ 26.1-36.12-17(3)(d)	0	
3(f)	Number of prior authorization requests submitted but not necessary	§ 26.1-36.12-17(3)(f)	0	
3(g)	Number of prior authorization requests submitted by electronic means	§ 26.1-36.12-17(3)(g)	0	
3(h)	Number of prior authorization requests submitted by nonelectronic means (mail and facsimile)	§ 26.1-36.12-17(3)(h)	0	
3(e)(1)	Patient did not meet prior authorization criteria	§ 26.1-36.12-17(3)(e)(1)	0	
3(e)(2)	Incomplete information submitted by the provider to the prior authorization review organization	§ 26.1-36.12-17(3)(e)(2)	0	
3(e)(3)	Treatment program changed	§ 26.1-36.12-17(3)(e)(3)	0	
3(e)(4)	Patient is no longer covered by the health benefit plan	§ 26.1-36.12-17(3)(e)(4)	0	
3(e) Other	Other reason not enumerated above (describe in Remarks)	—	0	
	TOTAL — All Adverse Determination Reasons		0	