EXTERNAL REVIEW REQUEST FORM

THIS EXTERNAL REVIEW REQUEST FORM must be filed with (insert State Insurance Dept. or New Directions, as applicable) within FOUR (4) MONTHS after receipt of an adverse benefit determination, which is a denial of payment on a claim or request for coverage of a health care service or treatment.

APPLICANT NAME: _____

☐ Covered Person/Patient ☐ Authorized Representative

COVERED PERSON INFORMATION

Name _____ Address _____

Phone # (Home) _____(Work) _____(Mobile) _____

INSURANCE INFORMATION

Name of Health Carrier _____

Covered Person Insurance ID# _____

Insurance Claim/Reference # _____

Health Carrier Mailing Address _____

_____

Health Carrier Phone # _____

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider _____

Address _____

_____

Phone # _____

Medical Record # _____

REASON FOR DENIAL OF BENEFITS (Please check one)

☐ Benefits for the health care services or treatment were denied based on a medical judgment, such as medical necessity, appropriateness of care, health care setting, level of care, or effectiveness of a treatment

☐ The health care service or treatment was determined to be experimental or investigational

☐ Coverage was rescinded

SUMMARY OF EXTERNAL REVIEW REQUEST

(Enter a brief description of the claim, the request for the health care service or treatment that was denied, or the basis of the rescission of coverage, and/or attach a copy of the denial of benefits letter from your health carrier.)

_____

_____

_____

_____

EXPEDITED REVIEW

If you need a fast decision, you may request that your external review be handled on an expedited basis. To complete this request, the treating health care provider must fill out the enclosed Form stating that a delay would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function, or would subject the Covered Person to severe pain (physical or emotional) that cannot be adequately managed without the requested health care service or treatment.

Is this a request for an expedited review?

☐ YES ☐ NO

SIGNATURE

To appeal the denial of benefits, this Form must be signed and dated, and the enclosed "Authorization For Use And Disclosure of Health Information" must be signed and dated. The enclosed "Appointment of Authorized Representative" must be completed and returned if applicable.

I, _____, hereby request an external review. I attest that the information provided in this "External Review Request Form" is true and accurate to the best of my knowledge.

_____ _____

Signature of Covered Person/Legal Representative or Authorized Representative

Date

_____

Authority of Legal Representative
(Parent, Guardian, or Specify)