EXTERNAL REVIEW REQUEST FORM

This External Review Request Form must be filed with the Idaho Department of Insurance **within four (4) months** after the date of issuance of a notice of final adverse benefit determination by your health carrier for a claim or request for coverage of a health care service or supply. You have the right to an external review only if the denial involved:

- The medical necessity, appropriateness, health care setting, level of care or effectiveness of your health care service or supply, or
- The health carrier's determination the health care service or supply was investigational.

If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final. Except in certain circumstances, you will have no further right to have your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.

APPLICANT NAME: _____

The applicant is the (check one): □ Covered Person/Patient □ Health Care Provider □ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____ Patient Name: _____

Mailing Address: _____

_____

Covered Person Phone #: Home (_____)_____ Work (_____)_____

HEALTH COVERAGE INFORMATION

Health Carrier Name: _____

Covered Person's Policy/ID#: _____

Claim/Reference #: _____

Health Carrier Mailing Address: _____

_____

Health Carrier Telephone #: (_____)_____

EMPLOYER INFORMATION (Include if the covered person's plan is through an employer)

Employer's Name: _____

Employer's Phone #: (_____) _____

Is the covered person's health coverage through an employer's self-funded plan? Yes ___ No ___
If you are not certain, please check with the employer. Most self-funded plans and federal employee programs are not eligible for external review with the exception of self-funded plans required to be registered with the Idaho Department of Insurance. However, some self-funded plans may voluntarily provide external review, but may have different procedures. Please check with the employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address:_____

_____

Contact Person: _____Phone: ( ) _____

Medical Record #:_____ Email Address: _____

REASON FOR HEALTH CARRIER DENIAL (Please check one. Attach a copy of the denial notice from the health carrier.)

- Denial for medically necessity, appropriateness, health care setting, level of care or effectiveness. Yes ____ No ____
- Denial as investigational (experimental). Yes ____ No ____

*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages.

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, your treating health care provider must fill out the attached Certification by Treating Health Care Provider form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes _____ No _____

SIGNATURE AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

Complete and sign the Authorization for Release of Medical Records, and if needed for your external review request, the Authorization for Release of Drug or Alcohol Abuse Records and Psychotherapy Notes.

Attach a photocopy of the insurance ID card from the health carrier.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE
(Fill out this section only if someone else will be representing you in this appeal.)

You may represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____
Signature of Covered Person (or legal representative)* Date
*(Parent, Guardian, Conservator or Other—Please Specify)

Mailing Address of Authorized Representative: _____

_____

Phone #: Daytime (_____) _____ Evening (_____)_____

Email Address: _____

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the disagreement with your health carrier. Indicate clearly the service(s) being denied and the specific date(s) being denied. Explain why you disagree. Attach additional pages if necessary and include available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies and any additional information from your physician/health care provider that you want the independent review organization reviewer to consider.

WHAT TO SEND AND WHERE TO SEND IT

PLEASE NOTE: Your request will not be accepted for full review unless all four (4) items below are included*.

1. □ **YES**, I have included this completed request form signed and dated.

2. □ **YES**, I have included the completed Authorization for Release of Medical Records and if needed, the Authorization for Release of Drug or Alcohol Abuse Records and Psychotherapy Notes, signed and dated.

3. □ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health carrier named in this request;

4. □ **YES****, I have enclosed the letter from my health carrier that states:
   (a) The carrier's decision is final and that I have exhausted all internal review procedures; or
   (b) The carrier has waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. Contact the Department of Insurance at:

700 W. State St.
P.O. Box 83720
Boise, ID 83720-0043
(208) 334-4250 or toll-free in Idaho, 1-800-721-3272

*Call the Department of Insurance at **208-334-4250** (or 1-800-721-3272 toll-free in Idaho) if you need help in completing this request form, or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to:

Idaho Department of Insurance
ATTN: External Review
700 W. State St.
P.O. Box 83720
Boise, ID 83720-0043

If you are requesting an expedited external review, call the Department of Insurance before sending your paperwork and you will receive instructions on the quickest way to submit the application and supporting information. Your request for an expedited review must include the attached Certification by Treating Health Care Provider form.

FOR EXPEDITED EXTERNAL REVIEW REQUESTS:
CERTIFICATION BY TREATING HEALTH CARE PROVIDER

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients may request an independent external review when a health carrier has denied a health care service or supply requested by a treating health care provider if the denial involved:

- The medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or supply, or
- The health carrier's determination the health care service or supply is investigational.

The Idaho Department of Insurance oversees external review requests for these denials. The standard external review process can take up to 42 days from the date the patient's external review request is submitted by our department to an independent review organization. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for a standard review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited review must be completed within 72 hours. This form provides the certification necessary to qualify for an expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

_____

Phone Number: (_____) _____ Fax Number: (_____)_____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

_____

Patient Name: _____

CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's external review request for the health carrier's denial of the requested health care service or supply should be processed on an expedited basis.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____ _____
Signature Date