External Review Request Sample Template

Within 4 months after receiving a final denial from your insurance company for coverage of a health care service or treatment, look at the Explanation of Benefits (EOB) and/or the final denial letter for the contact information for the organization in your state to request an external review.

[*In many - but not all - states, the state Department of Insurance handles external review requests.*]

State Department of Insurance
PO Box XXXX
City, ST XXXXX-XXXX
(888) 555-8888 (fax)
www.doi.state.gov

EXTERNAL REVIEW REQUEST

PATIENT NAME: ______________________________

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: ______________________________ Patient Name: ______________________________

Address: ____

____

Covered Person Phone Number: Home ______________________________ Work ______________________________

INSURANCE INFORMATION

Insurance Company: ____

Covered Person Insurance ID number: ______________________________

Insurance Claim/Reference number: ______________________________

Insurance Company Mailing Address: ______________________________

____

Insurance Company Phone: ______________________________

EMPLOYER INFORMATION

Employer's Name: ______________________________

Employer's Phone: ______________________________

Is the health coverage you have through your employer a self-funded plan? _______. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Provider: ______________________________

Provider Address: ______________________________

____

Contact Person: ______________________ Phone: ______________________

Medical Record Number (*if known*): ______________________________

REASON FOR HEALTH CARRIER DENIAL (Please check one)

______The health care service or treatment is not medically necessary.

______The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim/request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

____

____

____

*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 below.

EXPEDITED REVIEW

You may request that your external appeal be handled on an expedited basis if a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. To complete this request, your treating health care provider must fill out the attached form: Certification of Treating Health Care Provider for Expedited Consideration of a Patient's External Review Appeal.

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

SIGNATURE AND 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.

I, ______________________________, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and Department of Insurance. I understand that the independent review organization and Department of Insurance will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

______________________________ ______________________

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other – Please Specify)

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**.

Physician Certification
Experimental/Investigational Denials
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for ________________ (covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the covered person's treating physician, I hereby certify to the following:
(Please check all that apply) (NOTE: Requirements #1 - #3 below must **all** apply for the covered person to qualify for an external review).

☐ 1) The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

☐ 2) The covered person has a condition that qualifies under one or more of the following:

[please indicate which description(s) apply]:

- ☐ Standard health care services or treatments have not been effective in improving the covered person's condition;
- ☐ Standard health care services or treatments are not medically appropriate for the covered person; or
- ☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

☐ 3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

☐ 4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explain: ____

____

☐ 5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Explain: ____

____

6) Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. Attach additional sheets as necessary.

____

____

____________________________ Physician's Signature

____________________________ Date