# EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME:		Covered Person/
Patient Provider Authorized Representative		
COVERED PERSON/PATIENT INFORMATIO	<u>N:</u>	
Covered Person Name:	Patient Name:	
Address:		
Covered Person Phone #: Home ()	Work ()	
<b>INSURANCE INFORMATION:</b>		
Insurer/HMO Name:		
Covered Person Insurance ID#:		
Insurance Claim/Reference #:		
Insurer/HMO Mailing Address:		
Insurer Telephone #: ()		
<b>EMPLOYER INFORMATION:</b>		
Employer's Name:		
Employer's Phone #: ()		
Is the health coverage you have through your employed	loyer a self-funded plan?	If you are not
certain please check with your employer. Most self		
However, some self-funded plans may voluntarily procedures. You should check with your employer.	provide external review, but may	have different
procedures, rou should check with your employer.		

## **HEALTH CARE PROVIDER INFORMATION:**

Treating Physician/Health Care Provider:
Address:
Contact Person:Phone:( )
Medical Record #:
<b><u>REASON FOR HEALTH CARRIER DENIAL</u>:</b> (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, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)\*

<u>\*You</u> 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:**

**If you need a fast decision**, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached 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	
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### 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 by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Arkansas Insurance Department. I understand that the independent review organization and the Arkansas Insurance Department 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.

Sign	ature of Cov	ered Person (or	legal representativ	ve)*	]	Date	-
*(	_Parent,	_Guardian,	Conservator or	Other –	Please Spe	cify	)

### APPOINTMENT OF AUTHORIZED REPRESENTATIVE

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

You can 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.

Signa	ature of Cove	ered Person (or	· legal representative	)*	Date
*(	_Parent,	_Guardian,	Conservator or	_ Other – Please	Specify

Address of Authorized Representative:

Phone #: Daytime (\_\_\_\_\_)\_\_\_\_\_ Evening (\_\_\_\_\_)\_\_\_\_