HEALTH CLAIMS EXTERNAL REVIEW REQUEST FORM

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

This External Review Request Form must be filed with the Idaho Department of Insurance **within four (4) months** after the date of a notice of a final denial of benefits by your health insurance 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 insurance carrier's determination the health care service or supply was investigational.

As used herein, "you" or "your" always refers to the Covered Person/Patient.

If you request an independent external review of your claim, except in limited circumstances, the decision made by the independent reviewer will be binding and final and you will have no further right to have your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity. Please have the covered person initial the box at right to acknowledge this statement. Initial Here: ☐

WHAT TO SEND:

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

1. ☐ **YES**, the covered person has fully completed this form, including initialing the section above.
2. ☐ **YES**, the Authorization for Release of Drug or Alcohol Abuse Records and Psychotherapy Notes, if applicable, has been 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 insurance carrier named in this request; and
4. ☐ **YES**, I have enclosed the letter from my health insurance 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 insurance carrier's internal review procedures.
   (c) You may make a request for external review without exhausting all internal review procedures under certain circumstances.

APPLICANT NAME: _____

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

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____ Patient Name: _____

Mailing Address: _____

_____

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

Email Address: _____

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

You may represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. Complete this section ***only*** if someone else, including your Health Care Provider, will be representing you in this appeal. You may revoke this authorization at any time. The signature below MUST be the original signature of the covered person or a lawfully authorized person who is not the Authorized Representative. The lawfully authorized person can be a parent, guardian, conservator, attorney-in-fact, or, where the covered person cannot give consent, a family member or treating health care professional. If this is not clearly an original signature, the Idaho Department of Insurance will contact the covered person for verification, which may delay the processing of this review.

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

_____ _____

Signature of Covered Person (or other lawfully authorized person*) Date

*Parent, Guardian, Conservator, attorney-in-fact, etc. (Please Specify): _____

Mailing Address of Authorized Representative: _____

_____

Phone #: Daytime ( ) _____ Fax ( )_____

Email Address: _____

Note to Authorized Representative: The Idaho Department of Insurance will only discuss this external review with the person named as the authorized representative above.

HEALTH INSURANCE COVERAGE INFORMATION

Health Insurance Carrier Name: _____

Covered Person's Policy/ID#: _____

Claim/Reference #:_____

Health Insurance Carrier Mailing Address: _____

_____

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

Employer's Name:_____

Is the covered person's health coverage through an employer's self-funded plan? Yes ___ No ___

If you are unsure, 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 (or fax): _____

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

- Denial for medical necessity, appropriateness, health care setting, level of care or effectiveness.

  Yes ____ No ____
- Denial as investigational (experimental). Yes ____ No ____

Please also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using page 5.

EXPEDITED REVIEW

To qualify for an expedited review, the 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 _____

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.

Complete this page only if applicable:

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 insurance 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 insurance 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 forty-two (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 covered person'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 seventy-two (72) hours. This form provides the certification necessary to qualify for an expedited review.

Name of Treating Health Care Provider: _____

Mailing Address: _____

_____

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

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Patient/Covered Person 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 insurance 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

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the disagreement with your health insurance 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 insurance 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.

SIGNATURE AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

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

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.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I have requested an external review pursuant to Idaho Code Section 41-5906. In order to obtain that review, I understand that I must sign below to authorize my health insurance carrier, whose decision is the subject of this request, and its subcontractors and all applicable medical providers, to release all information relating to the decision to be reviewed including, but not limited to, my files and medical record information, which may include mental health information to the Idaho Department of Insurance (DOI). I authorize the DOI to provide or to instruct the health insurance carrier and/or its subcontractors and providers to provide such information to the independent review organization (IRO) assigned by the DOI to perform the external review.

I, _____, hereby reaffirm my request for an external review. I attest that the information provided in this request is true and accurate to the best of my knowledge. I authorize my health insurance carrier, its subcontractors and agents, and my health care providers to release all relevant medical or treatment records to the independent review organization (IRO) and the Idaho Department of Insurance (DOI). I understand the IRO will use this information to make a determination on my external review and the information will be kept confidential and not be released to anyone else. This release is valid for one year unless it expires sooner upon the IRO rendering a final decision or upon revocation. I understand that the decision of the IRO may be binding and that neither the DOI nor the IRO may authorize services in excess of those covered by my health plan.

I acknowledge that I may revoke this authorization at any time. My revocation will be effective upon receipt, but will not affect actions already taken on the basis of the authorization. In any event, this authorization expires upon the IRO rendering a final decision regarding this external review.

_____ _____

Signature of Covered Person Date

_____

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

*Parent (if patient is under 18 years old), guardian (if other than patient), conservator, attorney or other. If other than parent of minor, attach a written authorization to represent patient.

Send all paperwork to:

Mail: Idaho Department of Insurance **ATTN: External Review** **700 W. State St.** **P.O. Box 83720** **Boise, ID 83720-0043**	**FAX: 208-334-4398** **Email: consumeraffairs@doi.idaho.gov**

Complete this page only if applicable:

AUTHORIZATION FOR RELEASE OF DRUG or ALCOHOL ABUSE RECORDS AND PSYCHOTHERAPY NOTES

I have requested an external review pursuant to Idaho Code Section 41-5906. In order to obtain that review, I understand that I must sign below to authorize my health insurance carrier, whose decision is the subject of this request, and its subcontractors and all applicable medical providers, to release all information relating to the decision to be reviewed including, but not limited to, my files and medical record information, which may include mental health information, to the Idaho Department of Insurance (DOI). I authorize the DOI to provide or to instruct the health insurance carrier and/or its subcontractors and providers to provide such information to the independent review organization (IRO) assigned by the DOI to perform the external review. I acknowledge that information to be used or disclosed as a result of this authorization may include records that are protected by federal and/or state laws applicable to substance abuse and psychotherapy. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO PSYCHOTHERAPY, DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse and psychotherapy information disclosed as a result of this authorization will need my further written authorization to re-disclose this information.

I, _____, hereby reaffirm my request for an external review. I attest that the information provided in this request is true and accurate to the best of my knowledge. I authorize my Health insurance carrier, its subcontractors and agents, and my health care providers to release all relevant medical or treatment records to the independent review organization (IRO) and the Idaho Department of Insurance (DOI). I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO PSYCHOTHERAPY, DRUG AND/OR ALCOHOL ABUSE. I understand the IRO will use this information to make a determination on my external review and the information will be kept confidential and not be released to anyone else. This release is valid for one year unless it expires sooner upon the IRO rendering a final decision or upon revocation. I understand that the decision of the IRO may be binding and that neither the DOI nor the IRO may authorize services in excess of those covered by my health plan.

I acknowledge that I may revoke this authorization at any time. My revocation will be effective upon receipt, but will not affect actions already taken on the basis of the authorization. In any event, this authorization expires upon the IRO rendering a final decision regarding this external review.

_____ _____

Signature of Covered Person Date

_____ _____

Parent, Guardian, Conservator or Other (Please Specify*) Printed Name of "Other" Signatory

*Parent (if patient is under 18 years old), guardian (if other than patient), conservator, attorney or other. If other than parent of minor, attach a written authorization to represent patient.