EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME: ____
Covered Person/Patient or Provider Authorized Representative

COVERED PERSON/PATIENT INFORMATION:

Covered Person Name: ______________________________ Patient Name: ___________________________

Address: ____
____

Covered Person Phone #: Home (____)_______________________ Work (___)________________________

INSURANCE INFORMATION:

Insurer/HMO Name:____

Covered Person Insurance ID#:____

Insurance Claim/Reference #: ____

Insurer/HMO Mailing Address: ____

Insurer Telephone #: (_____)____

EMPLOYER INFORMATION:

Employer's Name:____

Employer's Phone #: (_____)____

Is the health coverage you have through your employer a self-funded plan? Yes ____ No ____

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 Physician/Health Care Provider: ____

Address: ____
____

Contact Person: ______________________________ Phone: (____) ____________________

Medical Record #: _____________________

REASON FOR HEATLH 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, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

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*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial. Attach additional sheets, if needed.

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 review? Yes _______ No ________

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.

____ _________________________

Signature of Covered Person (Patient/Member/Parent or Guardian) Date

Address of Authorized Representative:

____

____

____

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

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 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.

____ _______________

Signature of Covered Person (or legal representative)* Date

*___Parent, ____Guardian, ____Conservator or ___Other (Please Specify) ____________________________