EXTERNAL REVIEW REQUEST FORM

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW:

1. ☐ **YES**, I have included a completed external review request form signed and dated;

2. ☐ **YES**, I have included a copy of my insurance identification card or other evidence showing that I am insured by the health insurance company;

3. ☐ **YES**, I have enclosed the internal appeal denial letter from my health insurance company or utilization review company.

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

Oklahoma Insurance Department
External Review
400 NE 50TH STREET
OKLAHOMA CITY, OK 73105
FAX: 405-521-6652

Please note: For expedited reviews, the treating health care provider must fill out pages 6-9 of this 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.

EXTERNAL REVIEW REQUEST FORM

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Oklahoma Insurance Department within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for a health care service or treatment.

APPLICANT NAME _____

Please Check One: ☐ Covered person/Patient ☐ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

INSURANCE INFORMATION

Insurer/HMO Name: _____

Covered Person Insurance ID#: _____

Insurance Claim/Reference #: _____

Insurer/HMO Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurer Telephone #: (_____) _____

Is the insurance 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 Physician/Health Care Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Phone #: (_____)_____

Medical Record #: _____

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.

***You can describe in your own words the health care service or treatment in dispute using the lines below.**

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 PERTINENT MEDICAL RECORDS, IF AVAILABLE. YOU MUST ALSO ATTACH ANY INFORMATION YOU RECEIVED FROM YOUR HEALTH CARRIER CONCERNING THE DENIAL, AND ANY ADDITIONAL INFORMATION FROM YOUR PHYSICIAN/HEALTH CARE PROVIDER THAT YOU WANT THE INDEPENDENT REVIEW ORGANIZATION REVIEWER TO CONSIDER.

_____

_____

_____

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_____

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

If yes, please see certification section starting on Page 6.

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 Oklahoma Insurance Department. I understand that the independent review organization and the Oklahoma 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)

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 (or legal representative)* Date

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

Address of Authorized Representative: _____

City: _____ State:_____ Zip: _____

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

CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Oklahoma Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date an Independent Review Organization (IRO) is assigned to the case. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external 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 external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: (_____)_____ Fax #: (_____)_____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

Patient's Insurer Member ID#: _____

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 appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date

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 Insured'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, or a 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]:	
	i. ☐	Standard health care services or treatments have not been effective in improving the covered person's condition;
	ii. ☐	Standard health care services or treatments are not medically appropriate for the covered person; or
	iii. ☐	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 I have recommended would 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: _____ _____	

_____ _____

Physician's Signature Date

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 Name (Please Print)

Physician's Signature

Date