

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Nebraska Department of Insurance within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment. The Department of Insurance Mailing Address and Telephone Number is:

Nebraska Department of Insurance
PO Box 82089
Lincoln, NE 68501-2089
(877) 564-7323
www.doi.nebraska.gov

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME:

Covered
person/Patient

Provider
Authorized
Representative
(Choose One)

COVERED PERSON/PATIENT INFORMATION

Covered Person Name:

Patient Name:

Address:

Covered Person Home
Phone Number:

Work

INSURANCE INFORMATION

Insurer/HMO Name:

Covered Person Insurance ID number:

Insurance Claim/Reference number:

Insurer/HMO Mailing Address:

Insurer Phone Number:

EMPLOYER INFORMATION

Employer's Name:

Employer's Phone Number:

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 Physician/Health Care Provider:

Address:

Contact Person: Phone Number: ()

Medical Record Number:

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, the 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 the Nebraska Department of Insurance. I understand that the independent review organization and the Nebraska 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)*
*(Parent, Guardian, Conservator or Other – Please Specify)

Date

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

Date

Address of Authorized Representative:

Phone Number:

Daytime () _____ Evening () _____

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.**

Explain:

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. ____ **YES**, I have included this completed application form signed and dated.
2. ____ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
3. ____ **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
 - (a) Their decision is final and that I have exhausted all internal review procedures; or
 - (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Department of Insurance at the address and telephone number below.

4. ____ **YES**, I have included a copy of my certificate of coverage, my insurance policy benefit booklet, which lists the benefits under my health benefit plan OR provided a copy of my member ID number.

*Call the Nebraska Department of Insurance at (877) 564-7323 if you need help in completing this application 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.

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

Nebraska Department of Insurance
PO Box 82089
Lincoln, NE 68501-2089
www.doi.nebraska.gov

If you are requesting an expedited external review, call the Nebraska Department of Insurance before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

**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, 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)

Explain:

Physician's Signature

Date