



## EXTERNAL REVIEW REQUEST FORM

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

**If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final. Except in limited circumstances, you will have no further right to have your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.**

**APPLICANT NAME:** \_\_\_\_\_

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

### **COVERED PERSON/PATIENT INFORMATION**

Covered Person Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Covered Person Phone #: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

### **HEALTH COVERAGE INFORMATION**

Health Carrier Name: \_\_\_\_\_

Covered Person's Policy/ID#: \_\_\_\_\_

Claim/Reference #: \_\_\_\_\_

Health Carrier Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Health Carrier Telephone #: (\_\_\_\_\_) \_\_\_\_\_

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

Employer's Name: \_\_\_\_\_

Employer's Phone #: (\_\_\_\_\_) \_\_\_\_\_

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

If you are not certain, 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 #: \_\_\_\_\_

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

The health care service or supply is not medically necessary. Yes \_\_\_\_ No \_\_\_\_

The health care service or supply is experimental or investigational. Yes \_\_\_\_ No \_\_\_\_

\*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.

**EXPEDITED REVIEW**

**If you need a fast decision**, you may request that your external review be handled on an expedited basis. To complete this request, your 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 \_\_\_\_\_

**SIGNATURE AND AUTHORIZATION FOR 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.

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

Attach a photocopy of the insurance ID card from the health carrier.

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**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)

Mailing Address of Authorized Representative: \_\_\_\_\_

\_\_\_\_\_

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



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## WHAT TO SEND AND WHERE TO SEND IT

**PLEASE NOTE:** Your request will not be accepted for full review unless all five (5) items below are included\*.

1.  **YES**, I have included this completed request form signed and dated.
2. **YES**, I have included the completed Authorization for Release of Medical Records and if needed, the Authorization for Release of Drug or Alcohol Abuse Records and Psychotherapy Notes, 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 carrier named in this request;
4.  **YES\*\***, I have enclosed the letter from my health 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 carrier's internal review procedures.

\*\*You may make a request for external review without exhausting all internal review procedures under certain circumstances. Contact the Department of Insurance at:

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

5.  **YES**, I have included a copy of the certificate of coverage or the policy benefit booklet which lists the benefits under my health benefit plan.

\*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.

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

**Idaho Department of Insurance  
ATTN: External Review  
700 W. State St.  
P.O. Box 83720  
Boise, ID 83720-0043**

**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.



**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 carrier has denied a health care service or supply requested by a treating health care provider if the denial involved:

- The medical necessity of the health care service or supply, or
- The health carrier's determination the health care service or supply was investigational.

The Idaho Department of Insurance oversees external review requests for these denials. The standard external review process can take up to 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 patient'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 72 hours. This form provides the certification necessary to qualify for an expedited review.

**GENERAL INFORMATION**

Name of Treating Health Care Provider: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

Licensure and Area of Clinical Specialty: \_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Policy/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 external review request for the health 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