Request for External Review

Illinois Department of Insurance

Applicant

(person requesting the external review)

first name _____ last name _____

address _____

city _____ state _____ zip _____

daytime phone _____ email _____

applicant relationship to patient: (check 1 box below)

- ☐ enrollee/patient
- ☐ health care provider
- ☐ parent of minor child under 18
- ☐ legal or authorized representative (must provide valid written authorization)

Covered Person/Patient

(person for whom medical care was denied)

first name _____ last name _____

address _____

city _____ state _____ zip _____

daytime phone _____

Insurance Information

health carrier name _____

subscriber name _____

subscriber ID _____

dependent insurance ID _____

coverage is:

- ☐ individual plan
- ☐ group plan through employer – provide name _____
- ☐ group plan through plan sponsor – provide name _____

Health Care Provider

treating provider name _____

address _____

contact person _____ email _____ phone _____

Reason for Appeal

_____

provide type and dates of service being denied and attach pertinent documentation

adverse or final adverse determination date (copy must be provided) _____

Include the Following Items

- ✓ ID Card – copy of the patient's insurance identification card
- ✓ Final Denial Letter – copy of the final denial letter from the Health Carrier, denying your request at the final level of their internal appeals process; for expedited External Review, attach last denial letter received
- ✓ Valid written authorization for authorized representative or legal representative
- ✓ Physician Certification form – use this additional form if applying for expedited or experimental/investigational review; check all that apply:
  - ☐ Request for Expedited Review (complete Section A of Physician Certification form)
  - ☐ Request for Review of Experimental/Investigational Denial (complete Section B of Physician Certification form)

_____ _____

applicant signature date

Consent for External Review and Release of Medical Records

By signing below I hereby authorize the release of medical records necessary for the external review. I understand that these records may be obtained from the Health Carrier, the Utilization Review Company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this external review and may be viewed by an auditor of the Department of Insurance for quality review and examination of record purposes.

_____ _____ _____

signature of covered person/patient; if under 18, signature of parent; or legal or authorized representative (with copy of valid authorization) | relationship to patient | date

Important Information

- ✓ return this request and supporting attachments to:

  Illinois Department of Insurance
  Office of Consumer Health Insurance
  External Review Request
  320 W. Washington Street
  Springfield, IL 62767
  877-850-4740 toll free phone
  217-557-8495 fax
  Insurance.Illinois.gov/ExternalReview

- ✓ Filing Deadline – You have 4 months to file your external review after receipt of the final denial letter indication that the internal appeals have been exhausted.
- ✓ Expedited External Review for Urgent Care or Life Threatening Situations - Expedited external review requests should be filed immediately following receipt of any adverse determination.
- ✓ New Medical Information - Be sure to submit any new medical information that you wish to have considered. All previously submitted medical information will automatically be forwarded to the independent review organization by the health plan for consideration in this external review. If you are filing for an expedited review, please provide all additional information with this form; you may not be given another opportunity to provide this information.