# 

# External Review Request Form

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## If you are requesting an Expedited External Review, your provider must complete and sign ATTACHMENT A: PHYSICIAN CERTIFICATION FORM and submit at the same time with the External Review Request Form.

## Information on Covered Person (person who was denied the services)

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

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

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Telephone: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Fax) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Information on the Person Who is Authorized to Manage This Request for Covered Person

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Fax) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Covered Person (person who was denied health services):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By Checking this Box, I attest that I have obtained permission from the covered person to handle this external review on his/her behalf.**

**\*\*IF YOU ARE A LEGAL GUARDIAN, POWER OF ATTORNEY OR EXECUTOR, PLEASE ENCLOSE/ATTACH THE APPROPRIATE DOCUMENTS SHOWING YOUR AUTHORITY TO ACT ON BEHALF OF THE COVERED PERSON.**

Information about doctor or provider who is performing or recommending the service

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

Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext. \_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## About the Service that was Denied

The service that was denied is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The service in question has already been provided: Yes No

I have completed all levels of appeal offered by my insurer: Yes No

## Insurance Information

Insurance Company Name as it Appears on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Covered Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/Group Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**About the External Review I am Requesting:**

**Description of Disagreement:**

\_\_\_\_\_ I am requesting a Standard External Review, OR

\_\_\_\_\_ I am requesting an Expedited External Review and:

* The requested service has not already been provided;
* The covered person (check the applicable box):
* 1) Has received a noncertification decision;

2) Has filed a request for an expedited appeal with the insurer as required by NC law, a copy of which is enclosed/attached, or date verbally requested to insurer: **\_\_\_\_\_\_\_\_\_\_**; and

3) ATTACHMENT A– PHYSICIAN CERTIFICATION FORM has been completed and is enclosed/attached.

OR

* 1) Has received an appeal decision upholding a noncertification;

2) has filed a request for an expedited second-level grievance review of the noncertification as required by NC law, a copy of which is enclosed/attached or date verbally requested to insurer: **\_\_\_\_\_\_\_\_**; and

3) ATTACHMENT A– PHYSICIAN CERTIFICATION FORM has been completed and is enclosed/attached.

OR

* 1) Has received a second-level grievance review determination upholding a noncertification decision; and

2) ATTACHMENT A– PHYSICIAN CERTIFICATION FORM has been completed and is enclosed/attached.

OR

* 1) Has received a second-level grievance review determination upholding a noncertification decision; and

2)The second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

## Check list

\_\_\_\_ I have enclosed/attached a copy of my insurance card.

\_\_\_\_ I have enclosed / attached a copy of the final denial from my insurer.

\_\_\_\_ I have enclosed / attached medical records, radiology reports, test results specific to the denial.

\_\_\_\_ I have provided a description of the disagreement.

\_\_\_\_ I have submitted 3 copies of any CD’s that contain my medical records and/or x-rays.

\_\_\_\_ IF REQUIRED, I have provided a copy of the request for an expedited appeal or expedited second-level grievance review to the insurer, or the date the request was made to the insurer.

\_\_\_\_ IF REQUIRED, I have provided a completed copy of ATTACHMENT A– PHYSICIAN CERTIFICATION FORM.

**MEDICAL AUTHORIZATION RELEASE**

The undersigned individual has requested an External Review pursuant to Part 4 of Article 50 of Chapter 58 of the NC General Statutes. In order to perform that review, the undersigned authorizes the North Carolina Department of Insurance (“NCDOI”) to obtain from the Health Plan, whose decision is the subject of this request, and their subcontractors, all information relating to the decision which is being reviewed including, but not limited to, his/her files and medical record information, which may include mental health information. Payment of fees for obtaining these records is the responsibility of the undersigned**.** The undersigned also authorizes the NCDOI to provide, or to instruct the Health Plan and/or its sub-contractors to provide, such information to the Independent Review Organization (“IRO”) assigned by NCDOI to perform the External Review.

The undersigned also acknowledges the following:

* The undersigned consents to the use of a translation service to translate any contents of this document that are submitted in a language other than English. The use of the translation service shall be at the expense of Smart NC, which shall treat the provided information as confidential.
* NCDOI and/or the IRO may not be subject to the federal regulation pertaining to confidentiality and disclosure of medical records known as HIPAA. Despite the fact that HIPPA does not preclude NCDOI from re-disclosing medical record information, NCDOI and its agents are prohibited by North Carolina State law, specifically NCGS 58-2-105, from doing so for any purpose other than the review.
* The undersigned may revoke this authorization at any time. The revocation will be effective upon receipt by NCDOI but will not affect actions already taken on the basis of this authorization. In any event, this authorization will automatically expire upon NCDOI and/or the IRO rendering a final decision regarding this External Review.

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| --- | --- |
| Print Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DATE: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ACKNOWLEDGMENT OF RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS**

This area must be signed by the patient or patient’s authorized representative only when the records relating to the denied service contain information relating to drug or alcohol abuse. This should be signed in addition to the Medical Authorization Release.

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by federal and/or state laws applicable to substance abuse. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information.

Signature of patient or authorized representative, parent if patient is a minor, or Power of Attorney if Applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**North Carolina Department of Insurance**

**ATTACHMENT A – PHYSICIAN CERTIFICATION FORM**

**EXPEDITED EXTERNAL REVIEW REQUEST**

**(To Be Completed by Treating Physician)**

A consumer can request an external review of a noncertification decision by an insurer. A noncertification decision is when an insurer has denied, reduced, or terminated a health care service because the insurer has determined that the requested health care service does not meet the insurer’s requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness. A noncertification decision also includes an insurer’s denial for a service which is deemed to be experimental, investigational, or cosmetic.

The North Carolina Department of Insurance administers the State’s External Review program. The standard external review process can take up to 45 days from the date the request is received by the Department. An expedited external review is available if the patient’s treating health care provider certifies that adherence to the time frame for the standard external review would reasonably be expected to 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 within three (3) calendar days. This form is for the purpose of providing the certification necessary to trigger an expedited review.

**GENERAL INFORMATION:**

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

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

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

State Medical License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Patient’s Insurer and Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CERTIFICATION:** I hereby certify that: I am a treating health care provider for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereafter referred to as “the patient”); that, in my professional judgment, adherence to the time frame for conducting an internal expedited insurer appeal (4 days), an expedited second-level grievance review (4 days) or a standard external review (up to 45 days) of the noncertification decision would reasonably be expected to 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 request for an external review of the insurer’s noncertification decision of the requested health care service should be processed on an expedited basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date