

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)*

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: _____

Phone Number: Daytime () _____ Evening () _____

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 95087
Lincoln, NE 68509-5087
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.