Department of Consumer and Business Services
Division of Financial Regulation — Consumer Advocacy – 2
P.O. Box 14480
Salem, Oregon 97309-0405
Phone: 503-947-7984, Fax: 503-378-4351
888-877-4894 (toll-free)
350 Winter St. NE, Salem, Oregon
dfr.oregon.gov

For use by insurance companies only.

For questions, email us at exreview.ins@oregon.gov.

Send this form by email to exreview.ins@oregon.gov or fax to 503-947-7862.

Today's date: _____

* Type of review: ☐ Standard (30-day review) ☐ Expedited (3-day review)

If expedited (check one):

☐ Denial concerns an admission, availability of care, continued stay, or enrollee has received emergency services and remains hospitalized.

☐ The provider certified in writing that the ordinary time period for an external review would seriously jeopardize the life and health of the enrollee or the enrollee's ability to regain maximum function.

* **HIPAA release form:**

☐ Received ☐ Not received

* Date and time HIPAA release form received:

Date: _____ Time: _____

* Date and time insurer received the initial request for external review from the patient or representative:

Date: _____ Time: _____

* Date of insurer's final adverse benefit determination letter: _____

Insurer contact information:

* Name: _____

NAIC number: _____

* Street address or P.O. Box: _____

* City: _____ * State: _____ * ZIP: _____

* Contact person: _____

Title: _____

* Phone: _____ * Fax: _____

* Email: _____

Insurance Benefit Administrators
Attn: Claim Reviews
PO Box 2917
Shawnee Mission, KS 66201-1317
1027s1119

Patient contact information:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

* Name: _____

* Insurance ID number: _____

* Insurance claim reference number: _____

* Street address or P.O. Box: _____

* City: _____ * State: _____ * ZIP: _____

* Phone: _____ * Fax: _____

* Email: _____

Patient's physician:

Name: _____

Street address or P.O. Box: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Email: _____

Attorney or representative:

Name: _____

Street address or P.O. Box: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Email: _____

* Required field