Illinois Department of Insurance

Request for External Review

Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001
877-850-4740 (toll free)
217-557-8495 (fax)
http://insurance.illinois.gov

Updated - 12/11/2017

This form must be completed in its entirety. If any fields are not completed upon submission, it will be rejected

Is this request **URGENT**? Does the patient have a medical condition where the timeframe for completion of an expedited internal appeal (48 hours), a final adverse determination (15-30 days), or a standard external review (21-45 days) would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function?

☐ NO ☐ YES - (If yes, the Physicians Certification Expedited Review form is **REQUIRED**)

NOTE: By requesting an expedited external review, you are waiving any available appeal steps and will not have an opportunity to submit additional information after this request.

Patient Information			
Last	**First**		**MI**
Address	**City**	**State**	**Zip**
Phone Number	**Email**		

Insurance Information	
Insurance Company Name	**Policy ID**
Policy Holder Name	**Employer/Sponsor Name**
Plan Type **Individual Plan** ☐ **Group Plan - Employer** ☐ **Group Plan – Sponsor** ☐	

Health Care Provider			
Organization/Doctor's Name		**Phone Number**	
Address	**City**	**State**	**Zip**
Fax Number	**Email**		
Contact Person	**Contact Preference** **Mail** ☐ **Email** ☐ **Fax** ☐		

Reason for External Review	
If the denial reason is NOT listed, please call 877-850-4740 prior to filing	
Medical Necessity ☐ **Pre-existing Condition** ☐ **Rescission of Coverage** ☐ **Experimental/Investigational** ☐	
Date(s) of Service (REQUIRED)	**Date of Denial (attach letter if possible)**

Please describe the procedure, treatment or drug that is being denied and why you disagree

REQUIRED

Request for External Review Checklist

Include the Following Items:

☐ **Proof of Legal Representation** – **REQUIRED IF** the applicant is not the patient or parent of the minor child.

☐ **Physician Certification Experimental/Investigational Form** – **REQUIRED IF** the health care service or course of treatment has been denied on the basis that the drug, procedure, therapy or services has been determined to be experimental or investigational. Must be completed by the treating provider.

☐ **Physician Certification Request for Expedited Form** – **REQUIRED IF** the covered person has a medical condition where the timeframe for completion of an expedited internal appeal (48 hours), a final adverse determination (15-30 days), or a standard external review (21-45 days) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. *By requesting an expedited external review, you are waiving appeal steps and you will not have an opportunity to submit additional information after this request.*

☐ **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 an expedited External Review, attach the last denial letter received.

☐ **ID Card** – A copy of the patient's insurance identification card.

☐ **Related Medical Records and Supporting Documentation** – Include any documentation that supports your assertion that this medical treatment should be covered, such as available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies, and any additional information from the physician/health care provider that you want the independent review organization to consider.

Important Information

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 following receipt of any adverse determination. Please provide all additional information with this form; you will not be given another opportunity to provide this information.

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.

Patient Consent for External Review and Release of Medical Records

Patient, Parent of a Minor Child, or Legal Representative

(Legal Representative - guardian, power of attorney, executor or administrator - MUST attach official documentation).

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 insurance 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.

Patient, Parent or Legal Representative Signature ONLY _____ **Date** _____

IF YOU ARE NOT THE PATIENT, PARENT OR LEGAL REPRESENTATIVE

Please complete the "Appointment of Authorized Representative" Form and submit with this request.

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

Fax Number - 217-557-8495
Message Center Website - https://mc.insurance.illinois.gov/messagecenter.nsf
Email - doi.externalreview@illinois.gov