Appendix B

EXTERNAL REVIEW REQUEST FORM

SECTION 1. ELIGIBILITY FOR EXTERNAL REVIEW

This External Review Request Form must be filed with the Iowa Insurance Division within **four months** after your health carrier denied, reduced or terminated the requested health care service or treatment or payment for the service or treatment. You or your authorized representative may request an external review under any of the following circumstances:

1. Your health carrier has made a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, and Section 7 if you are requesting an expedited review.**

2. Your health carrier has made a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, Section 6, and Section 7 if you are requesting an expedited review.**

3. The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which you received emergency services, but you have not been discharged from a facility. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, and Section 7.**

If coverage was denied for a service or treatment specifically listed in your health insurance policy as excluded from coverage (other than what is listed in paragraphs 1 and 2 above), you will not be eligible for external review.

You also will need to have completed any internal appeals with your health carrier before you can request an external review, unless:

1. You already did request an internal appeal with your health carrier and have not received a decision and it has been 30 days since you requested the appeal; or

2. Your health carrier has waived the requirement that you complete an internal appeal before requesting an external review; or

3. You need an expedited review because time is a factor in your treatment.

SECTION 2. WHAT TO SEND AND WHERE TO SEND IT

YOU MUST SUBMIT ITEMS 1 AND 2 BELOW:

1. This External Review Request Form, signed and dated, with the sections completed for your particular situation as described in Section 1. If you would like help completing your external review request for submission, contact the Market Regulation Bureau of the Iowa Insurance Division by calling 515-654-6600, or by email at iid.marketregulation@iid.iowa.gov.

2. One of the following:

   a. The letter from the covered person's health carrier or utilization review company that states that the decision is final and that the covered person or the covered person's authorized representative has exhausted all internal appeal procedures;

   b. The letter from the covered person's health carrier or utilization review company that states it has waived the requirement to exhaust all of the health carrier's internal appeal procedures;

   c. A copy of the covered person's or the covered person's authorized representative's request for internal appeal and a statement that no decision from the health carrier has been received for 30 days; or

   d. A completed request for expedited review, Section 7 of this form.

WHERE TO SEND IT:

If you are requesting a standard external review, send all paperwork to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; facsimile 515-654-6500; email iid.marketregulation@iid.iowa.gov. If you have questions, telephone 877-955-1212 or 515-654-6600.

If you are requesting an expedited external review, call the Iowa Insurance Division (telephone 877-955-1212 or 515-654-6600) before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

SECTION 3. INFORMATION REQUIRED FOR ALL EXTERNAL REVIEW REQUESTS

APPLICANT NAME

The applicant is a:

☐ Covered Person/Patient

☐ Provider (the covered person/patient must complete Section 4)

☐ Authorized Representative (submit completed Sections 4 and 5)

COVERED PERSON/PATIENT INFORMATION

Covered Person's/Patient's Name:
Address:
Telephone Number:
Daytime:
Evening:
Email Address:
Fax Number:

INSURANCE INFORMATION

Name of Insurer or HMO:
Covered Person's Insurance ID Number and/or Policy Number:
Insurance Claim/Reference Number:
Insurer/HMO Mailing Address:
Insurer/HMO Telephone Number:
Insurer/HMO Email Address:
Insurer/HMO Fax Number:

EMPLOYER INFORMATION

Employer's Name:

Is the health coverage that you have through your employer a self-funded plan? (Y/N)_____.

Some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider:
Address:
Contact Person:
Telephone Number:
Email Address:
Fax Number:
Patient Medical Record Number:

REASON FOR HEALTH CARRIER'S DENIAL

(Please check one.)

☐ The health care service or treatment was denied due to medical necessity, appropriateness, health care setting, level of care or effectiveness.

☐ The health care service or treatment is experimental or investigational (submit completed Section 6).

☐ Other: _____.

SUMMARY OF EXTERNAL REVIEW REQUEST

Enter a brief description of the claim and the request for health care service or treatment that was denied and attach a copy of the denial from your health carrier.

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the health care service or treatment decision in dispute and why you are appealing this denial. Indicate clearly the services being denied and the specific dates for the services being denied. Explain why you disagree. Attach additional pages if necessary and include 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 your physician or health care provider that you want the independent review organization to consider.

SECTION 4. 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 review. 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. I understand that the independent review organization will use this information to make a determination on my external review and that the information will be kept confidential and will not be released to anyone else. This release is valid for one year.

_____

Signature of covered person/patient or legal representative (parent, guardian, conservator or other – please specify)

Date:

SECTION 5. APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this request for external review.)

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 external review request on my behalf.

_____

Signature of covered person/patient or legal representative (parent, guardian, conservator or other – please specify)

Date:

Address of Authorized Representative:
Authorized Representative's Telephone Number:
Daytime:
Evening:
Fax Number:
Email Address:

SECTION 6. REQUEST FOR EXTERNAL REVIEW OF DENIALS BASED ON THE REASON THAT THE TREATMENT WAS EXPERIMENTAL OR INVESTIGATIONAL

PHYSICIAN CERTIFICATION: EXPERIMENTAL OR INVESTIGATIONAL DENIALS

(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____ (covered person's/patient's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance carrier's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person/patient to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's/patient's medical condition meets certain requirements:

In my medical opinion as the insured's treating physician, I hereby certify to the following:

(**NOTE:** Requirements 1 through 3 below must all apply for the covered person/patient to qualify for an external review.)

1. The covered person/patient has a condition that qualifies under one or more of the following descriptions.

   (Please check all descriptions that apply.)

☐ Standard health care services or treatments have not been effective in improving the covered person's/patient's condition.

☐ Standard health care services or treatments are not medically appropriate for the covered person/patient.

☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

2. The physician is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition.

3. Scientifically valid studies using accepted protocols demonstrate that the health care service or treatment recommended or that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person/patient than any available standard health care services or treatments.

Explain:

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional information as necessary.)

Physician's Signature_____ Date: _____

Physician's Name (Please print.)_____

SECTION 7. REQUEST FOR EXPEDITED EXTERNAL REVIEW

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED EXTERNAL REVIEW REQUEST

(To Be Completed by Treating Health Care Provider)

NOTE TO THE TREATING HEALTH CARE PROVIDER:

The standard external review process can take up to 60 days from the date the patient's request for external review is received by the Iowa Insurance Division.

The independent review organization should complete an expedited external review within 72 hours.

This form is for the purpose of providing the certification necessary to trigger expedited review.

CERTIFICATION

I hereby certify that I am a treating health care provider for the patient, _____; and that one of the following is true: (Please check all that apply.)

☐ Adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

☐ The recommended or requested health care service or treatment that is the subject of the external review request would be significantly less effective if not promptly initiated.

☐ The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which the patient received emergency services, but has not been discharged from a facility.

For this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Signature_____ Date_____

Treating Health Care Provider's Name (Please print.) _____

Provider's Mailing Address:
Telephone Number:
Email Address:
Fax Number:

Licensure and Area of Clinical Specialty:

[**ARC 2601C**, IAB 6/22/16, effective 7/27/16; **ARC 4780C**, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20; **ARC 6121C**, IAB 12/29/21, effective 2/2/22; **ARC 6338C**, IAB 6/1/22, effective 7/6/22]