

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

Return Request to:

CONNECTICUT INSURANCE DEPT
Attn: External Review
P.O. Box 816 • Hartford, CT 06142-0816



For Overnight Mail Only:

CONNECTICUT INSURANCE DEPT
Attn: External Review
153 Market Street • Hartford, CT 06103

Telephone: 1-860-297-3910 Email: externalreview@ct.gov

APPLICANT (Person requesting the external review) (Applicant must be 18 years or older)

Applicant Name: _____

Applicant Address: _____

Applicant Daytime Phone: _____ E-mail: _____

Check One: [] Enrollee/Patient [] Parent of Minor Child under 18 [] Authorized Representative (See page 2)

ENROLLEE/PATIENT (Person for whom requested services were denied)

Enrollee Name: _____

Enrollee Address: _____

Enrollee Phone: _____

INSURANCE INFORMATION

Insurance Company/Health Plan Name: _____

Subscriber Name: _____

Subscriber Insurance ID: _____ Dependent Insurance ID: _____

Coverage is: [] Individual Plan [] Group Plan - Employer Name: _____

PROVIDER INFORMATION

Treating Medical Provider: _____

Address: _____

Contact Person: _____

Email: _____ Telephone: _____ Extension: _____

PLEASE EXPLAIN THE REASON FOR THE APPEAL

Indicate clearly the type of service(s) and the specific date(s) of service being denied. Attach additional pages if necessary.

Three horizontal lines for providing the reason for the appeal.

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APPOINTMENT OF AUTHORIZED REPRESENTATIVE: *(Complete if applicant is other than patient or parent of a minor child.)*

I appoint _____, to act as my authorized representative for the purposes of section 38a-591g of the Connecticut General statutes, dealing with external review of final adverse determinations for medical necessity.

I authorize _____ to make any request; to present or to elicit evidence; to obtain review information; and to receive any notice in connection with my review, wholly in my stead. I understand that personal medical information related to my review may be disclosed to the representative indicated.

**Signature of Patient (parent if patient is under 18 years old)
Or Legal Representative*** (Guardian, Conservator or Other – Please specify)

Relationship
(If other than patient)

Date

* Legal Representatives must attach legal authorization to represent

This designation will expire one (1) year from the date it was signed, upon revocation or upon a final determination being rendered upon the action, whichever occurs sooner. Upon expiration, a new designation must be written in order to be valid. You may cancel this designation in writing at any time.

CONSENT FOR EXTERNAL REVIEW and RELEASE of MEDICAL RECORDS

I, _____ hereby authorize the release of medical records necessary for the external review. I understand that these records may be obtained from the Insurance Company/Health plan, 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 Insurance Department for quality review and examination of record purposes.

I understand that by providing my e-mail address I consent to receiving communications on an electronic basis in relation to this request from the Connecticut Insurance Department and the designated review entity. Any communications containing personally identifiable information, including medical information, are protected by state and federal privacy laws.

I understand that the decision of the independent review organization is binding and that neither the Commissioner nor the independent review organization may authorize services in excess of those covered by my health benefit plan.

**Signature of Patient (parent if patient is under 18 years old)
Or Legal Representative*** (Guardian, Conservator or Other – Please specify)

Relationship
(If other than patient)

Date

* Legal Representatives must attach legal authorization to represent

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EXTERNAL REVIEW CHECKLIST

Your request will not be processed if we do not receive all required items.

REQUIRED ITEMS

(√) Check all items enclosed

- 1. **External Review Application** – Completed, signed and dated.
- 2. **ID Card** – Copy of the patient’s insurance identification card
- 3. **Final Denial Letter** – Written notice from your health plan telling you that you have exhausted the internal appeals/grievance process. For expedited External Reviews please attach the last denial letter received.
- 4. **Filing Fee** Check or money order for \$25 payable to “Treasurer, State of Connecticut” - **OR** - **Request for Waiver of Filing Fee**
By checking this box, I attest that the covered person is indigent or unable to pay the filing fee, or the covered person has already paid the maximum fee of \$75 per calendar year.

EXPEDITED REQUEST: Yes No *Not available if services have already been delivered.*

(√) Check appropriate box

- 5. **Behavioral Health Denial**
(Automatically expedited – No Physician Certification Needed)
The denial of services is related to (A) a substance use disorder; or (B) co-occurring mental disorder; or (C) a mental disorder requiring 1) Inpatient Services, 2) Partial Hospitalization, 3) Residential Treatment, or 4) Intensive Outpatient Services necessary to keep a covered person from requiring an inpatient setting.
- OR -
 Physician Certification Form – Supplement A
Required for Expedited Requests – Completed and signed by your physician

EXPERIMENTAL/INVESTIGATIONAL DENIAL: Yes No
Services have been denied as experimental and/or investigational by your insurance company

- 6. **Physician Certification Form – Supplement B**
Required for Experimental/Investigational Denials – Completed and signed by your physician

OPTIONAL:

- 7. **New Medical Information Enclosed**
Medical documentation not previously submitted including additional supporting documentation from your treating physician.

Please note: All previously submitted medical information will automatically be forwarded to the independent review organization by the health plan for consideration in this external review.



Need assistance? Please call our Consumer Affairs Unit at 1-860-297-3910.

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IMPORTANT INFORMATION

- **Filing Deadline**
You have 120 days to file your external review after receipt of the final denial letter indicating 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 receipt of any adverse determination. Your doctor must sign the Physician Certification Form to authorize this request unless your request is for a behavioral health service that is automatically considered urgent.
- **Additional new medical information**
It is important when filing an External Review to submit complete documentation to support your request for approval of the denied services or treatment. You may ask your treating physician to provide information to support your External Review.

Important supporting documentation may include:

- Letters of support from treating providers
- Detailed provider treatment notes
- Enrollee/parent narratives describing the health issue, when it arose and accompanying symptoms

Please note: All previously submitted medical information will automatically be forwarded to the independent review organization by the health plan for consideration in this external review.

- **External Review Consumer Guide**
The Connecticut Insurance Department has published an important guide to assist you in understanding the External Review process. If you have not yet received your Consumer Guide from your health plan, you may download a copy of “A Consumer’s Guide to Appealing Health Insurance Denials” from the “Forms and Application” section of our website at www.ct.gov/cid.

MAILING INSTRUCTIONS

Please mail your application for External Review to:

Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford CT 06142-0816

For overnight delivery only:
Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford CT 06103



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REQUEST FOR EXTERNAL REVIEW

SUPPLEMENT A – Expedited Requests

PHYSICIAN CERTIFICATION FORM

NAME OF ENROLLEE/PATIENT:

Notice to the Treating Health Care Provider

The enrollee/patient listed above has requested an external review because his/her health carrier has denied a health care service or course of treatment on the basis that the service does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service.

In order for the covered person to obtain an expedited external review, the patient's treating health care provider must certify that the standard external review process of 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.

Please Note:

- Expedited reviews are only available if services have not yet been rendered.
- External Reviews for a denial of services related to (A) a substance use disorder; or (B) co-occurring mental disorder; or (C) a mental disorder requiring 1) Inpatient Services, 2) Partial Hospitalization, 3) Residential Treatment, or 4) Intensive Outpatient Services necessary to keep a covered person from requiring an inpatient setting will automatically be expedited and do not require this Form.

I certify that I am the treating physician; that adherence to the time frame for conducting a standard external review for the above named patient 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; and for this reason, the patient's appeal of the denial by the health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Physician Signature

State Medical License #

Date

Name of Treating Physician:

Physician Address:

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SUPPLEMENT B – Experimental/Investigational Denials

PHYSICIAN CERTIFICATION FORM

NAME OF ENROLLEE/PATIENT:

Notice to the Treating Health Care Provider

The enrollee/patient listed above has requested an external review because his/her health carrier has denied a health care service or course of treatment based on their determination that this drug, procedure or therapy is experimental and/or investigational.

In order for the covered person to obtain an external review of an experimental/investigational denial, the treating physician must certify that the covered person’s medical condition meets certain requirements.

I certify that I am the treating physician for the patient named above in this external review and that I have requested the authorization for a drug, device, procedure or therapy which has been denied for coverage due to the insurance company’s determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person’s medical condition meets certain requirements as shown below.

In my medical opinion as the insured’s treating physician, I hereby certify that **one or more** of the following situations is applicable:

- Standard health care services or treatments have not been effective in improving the medical condition of the covered person.
- Standard health care services or treatments are not medically appropriate for the covered person.
- There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment.

It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person, and which has been denied, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Physician Signature

State Medical License #

Date

Name of Treating Physician:

Physician Address:
