

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

Return Request to:
STATE OF CONNECTICUT INSURANCE DEPARTMENT
ATT: External Review
P.O. Box 816 ♦ Hartford, CT 06142-0816
1-860-297-3910 ♦ externalreview@ct.gov

FOR OVERNIGHT MAIL ONLY: 153 Market Street • Hartford, CT 06103

APPLICANT NAME (Person requesting the external review)

Applicant Name: _____

Applicant Address: _____

Applicant Daytime Phone #: _____ E-mail: _____

- Enrollee/Patient Parent of Minor Child under 18 Provider Legal or Authorized Representative

ENROLLEE/PATIENT (Person for whom medical care was 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 through Employer – Employer Name:
Group Plan through Plan Sponsor – Plan Sponsor Name:

PROVIDER INFORMATION

Treating Physician: _____

Address: _____

Contact Person: _____ E-mail: _____ Telephone: _____

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 and include pertinent medical records, if available.

Three horizontal lines for providing the reason for the appeal.

PLEASE INCLUDE THE FOLLOWING ITEMS WITH YOUR APPLICATION

1. **ID Card** - Copy of the patient's insurance identification card
 2. **Final Denial Letter** - Copy of the final denial letter from the Insurance Company/Health Plan, denying your request at the final level of their internal appeals process. For expedited External Review attach last denial letter received.
 3. **Filing Fee** - Check or money order for \$25 made payable to "Treasurer, State of Connecticut"
- OR
- Request for Waiver of Filing Fee** - 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.
4. **Physician Certification Form** (If applying for expedited or experimental/investigational review)
Check all that apply:
 - Request for Expedited External Review**
 - Request for Review of Experimental/Investigational Denial**

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 Insurance Company/Health Plan.

Signature of Patient (or parent if patient is under 18 years old)
or Legal Representative with valid written authorization to represent

Relationship

Date

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.
- **New medical information**
Please 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.

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

PHYSICIAN CERTIFICATION FORM
Supplement to Request for External Review

NAME OF ENROLLEE/PATIENT: _____

NAME & ADDRESS OF TREATING PHYSICIAN: _____

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, effectiveness of the health care service, or considers the drug, procedure or therapy to be experimental and/or investigational.

Expedited Review - SECTION A

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. For this reason, the treating physician must certify that the patient's appeal of the denial by the health carrier must be processed on an expedited basis.

Experimental/Investigational Review - SECTION B

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 as shown in Section B.

Please note that if the treating physician determines that the request for an experimental/investigation review should also be conducted on an expedited basis, the authorizations in both Section A and Section B should be completed.

SECTION A

REQUEST FOR EXPEDITED REVIEW
Only available if services have not yet been rendered.

Physician Authorization

I, _____, certify that in my opinion, the above named patient who has received an adverse determination for the medical services that I have recommended as medically necessary requires such review to be provided on an expedited basis because a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Physician Signature

State Medical License #

Date

(OVER)

SECTION B

REQUEST FOR REVIEW OF EXPERIMENTAL/INVESTIGATIONAL DENIAL

Physician Authorization

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 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 in this form.

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

Please check all that apply: *Note: Items 1, 2 and 3 must all apply to qualify for an external review.*

1. The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

2. The covered person has a condition that qualifies under one or more of the following:
Please check all that apply:
 - a. Standard health care services or treatments have not been effective in improving the covered person's condition;
 - b. Standard health care services or treatments are not medically appropriate for the covered person; or
 - c. 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.

3. The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Explanation: _____

4. The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explanation: _____

5. 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 health care services or treatment.

Explanation: _____

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

Explanation: _____

Physician Signature

State Medical License #

Date