STATE OF ALASKA
DIVISION OF INSURANCE
550 W. 7th Avenue, Suite 1560 Anchorage, Alaska 99501-3567
Tel.: (907) 269-7900 Fax: (907)269-7910 TTY/TDD: 711 or (800) 770-8973

EXTERNAL REVIEW APPLICATION FORM

For expedited (emergency) reviews, follow instructions in Section V

Note: Not all claims are eligible for external review. In most cases, the insurance company's internal grievance (appeal) process must be exhausted before requesting an external review. Contact the Division of Insurance if you are unsure about your eligibility to file for an external review.

Applicant Name:_____

☐ Covered Person/Patient ☐ Authorized Representative

Section I – Covered Person/Patient Information

Covered Person/Patient Name: _____

Mailing Address: _____City: _____

State: _____ Zip code: _____Daytime Phone: _____

Evening Phone: _____ Email: _____

Please complete if the covered person/patient is under age 18:

Name: _____**parent** ☐ or **legal guardian** ☐

Mailing Address: _____City: _____

State: _____ Zip code: _____ Daytime Phone:_____

Evening Phone: _____ Email: _____

Section II - Insurance Plan Information

Health Insurance Company: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Email: _____

(If more than one insurance company is involved with your claim, please attach contact information.

Primary Insured/Policy Holder: _____

Policy Number: _____ Claim/Reference Number: _____

If the insurance plan is provided through an employer, please provide

Employer Name: _____ Telephone _____

Address:_____City:_____State:_____Zip:_____

Is the employer's insurance plan self-funded? * Yes: ☐ No: ☐

*** If you are not certain, please check with your employer. Self-funded plans are not eligible for external review through the Division of Insurance. If you are participating in a self-funded plan, you must follow the plan procedures for external review.**

Section III – Information about the Patient's Health Care Provider

Name of Treating Health Care Provider:_____

Clinical Specialty:_____

Treating Provider's Contact Person: _____

Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Phone Number: _____ Fax Number:_____

which you are requesting an external review?

Note: Unless extended under 3 AAC 28.954, a covered person has 180 days to file for external review.

Section IV – Health Care Decision in Dispute

When did you receive notice from your insurance company regarding the adverse benefit determination (denial) for which you are requesting an external review? _____

Describe the health insurance company's reason for denial in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree with the insurance company.

Please attach any supporting documents to help describe the decision in dispute, including:

- all pertinent medical and insurance records;
- a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary;
- any pertinent peer literature, clinical studies or other information for consideration by the independent review organization;
- for experimental/investigational treatment, a certification from the treating physician regarding their qualifications along with their certification of the ineffectiveness or lack of availability/appropriateness of standard treatment and that the recommended treatment is likely to be more beneficial to the covered person.

Multiple fillable lines below (Attach additional Pages if necessary)

Continued on next page

Continued from previous page

Section V – Expedited Review

Complete this section **only if** your request qualifies for expedited review.

Expedited reviews are not available for retrospective adverse determinations.

To request expedited review, the applicant must effectively demonstrate that delayed treatment would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. A notice from the patient's medical provider demonstrating the urgent nature of the specific treatment should be attached with the request.

Do you request an expedited review? Yes ☐ No ☐
Is the notice from the patient's medical provider attached? Yes ☐ No ☐

Applications for Expedited External Review may be faxed to **(907)269-7910** or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Alaska Division of Insurance for additional instructions at **(907) 269-7900** or **(800) INSURAK** (in Alaska, outside Anchorage).

VI – Authorized Representative Designation/Certification

Complete this section **only if** someone else is representing the covered person in the Appeal. You may ask another person, including the treating health care provider, to act as your authorized representative and may revoke the authorization at any time.

A. Designation of Authorized Representative:

I hereby authorize_____(name) to act on my behalf in relation to this external review process.

_____ _____

Covered Person Signature **(If Legal Representative – attach power of attorney or other documentation)** Date

Authorized Representative

Mailing Address:_____

City _____ State: _____ Zip:_____

Daytime Phone: _____ Evening: _____

B. Legal Designation:

Legal Documentation is attached to establish that _____ (name) is authorized by law to provide consent on behalf of the covered person.

C. Family member or treating healthcare provider certification:

I _____ (name) hereby certify that I am a family member ☐ treating health care provider ☐ and that the covered person listed in Section I is unable to provide consent.

_____ _____

Signature Date

Mailing Address:_____

City: _____ State:_____ Zip:_____

Daytime Phone: _____ Evening:_____

VII - Authorization and Release of Medical Records

To appeal your health carrier's denial, you must sign and date this external request form and consent to release medical records.

I,_____, hereby request an external review and authorize the covered person's insurance company and health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the Alaska Division of Insurance (DOI). If approved for external review, I understand that the IRO and the DOI will use this information to make a determination to either reverse or uphold the insurer's determination. I also understand that the information will be kept confidential. I further understand that neither the Director nor the IRO may authorize services in excess of those covered by the patient's health care plan. Unless revoked, this release is valid for one year. I attest that the information provided in this application is true and accurate to the best of my knowledge.

Sign Here _____ _____

Signature Date

I am the

Covered Person ☐

Parent or Legal Guardian*: ☐

Authorized Representative*: ☐

***Attach Power of attorney or other documentation such as birth certificate or court-ordered legal guardianship**

Applicant Checklist

Before submitting this application, please verify that you have …

☐ Completed all relevant sections of the External Review Application Form.

- If appointing an authorized representative, the patient must complete Section VI.
- If requesting an Expedited External Review, Section V must be completed and the Provider Certification Form must be submitted.

☐ Signed and dated the External Review Application Form in Section VII.

☐ Attached the following documents:

- A photocopy of the covered person's insurance card or other evidence that the covered person is insured by the health or dental insurance company named in the appeal.
- A copy of the health insurance company's explanation of benefits, grievance determination, and all related documents to illustrate that you have exhausted the insurance company's internal grievance procedures regarding the final adverse determination that you would like to have externally reviewed.
- Any medical records, statements from the treating health care provider(s), or other information that you would like the Independent Review Organization to consider during the external review.
- If the request relates to experimental/investigational treatment, a certification from the treating physician regarding their qualifications and their certification of the ineffectiveness or lack of availability/appropriateness of standard treatment options and that the recommended treatment is likely to be more beneficial to the covered person.
- If requesting an Expedited External Review, a notice from the treating provider or other documentation to demonstrate the immediate need for a determination of coverage for future medical treatment/services.