REQUEST FOR EXTERNAL REVIEW

Instructions

1. If you are eligible and have completed the appeal process, you may request an external review of the denial by an External Review Organization (ERO). ERO reviews are only for denials that were based upon lack of medical necessity or the experimental or investigational nature of the request or service. You must submit a request for external review within the timeframe specified in the first or final denial letter.
2. A copy of the denial letter, as well as all other information you wish to be considered by the ERO, must be attached to this form. The decision made by the ERO will be based on the information submitted and the terms and conditions of your insurance plan. Active Health will provide the ERO with the information used during the review process.
3. An Expedited External Appeal can be requested by the treating provider by calling or faxing this document. **Telephone requests have to be followed up with this form.** Expedited External Reviews are available when your treating provider certifies the medical urgency of your situation. "Medical urgency" means that a delay in coverage of the service or treatment would jeopardize your health.
4. Send this completed form and all other information to: Active Health Management
   Attention: Appeal Department
   P.O. Box 221138
   Chantilly, VA 20153 - 1138
   Toll Free Telephone Number :<MORG ADD 3>
   Fax Number**:** 1-855-231-1218

Name of person filing request for external review:

Relationship to covered person: ❒Covered Person/Applicant
❒Authorized Representative ***(please complete the Appointment of Authorized Representative section)***

How would you like us to contact you? ❒Phone ❒Fax ❒Email ❒Mail

Contact information of authorized representative (if applicable)

Mailing Address:
Daytime Phone: Evening Phone:
Email Address: Fax:

Covered Person/Applicant Information

Name: ID Number:
Mailing Address:
Daytime Phone: Evening Phone:
Email Address: Fax:

Treating Physician/Health Care Provider Information

Name:
Mailing Address: Phone Number:
Email Address: Fax Number:
Contact Person: Phone Number:

External Review Specifications

1. If your situation is urgent, are you requesting an expedited review?
   ❒YES ❒NO

If you answer yes, your physician must complete the Treating Physician Certification Form for Internal Appeal and/or External Review.

2. Is your requested health care service considered an experimental or investigational treatment?
   ❒YES ❒NO

If you answer yes, your physician must complete the Treating Physician Certification for Experimental/Investigational Adverse Benefit Determinations.

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____
_____
_____
_____
_____

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may 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 on my behalf.

_____

Signature of Covered Person (or legal representative**) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I _____ hereby request an external review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, health care provider and/or health plan issuer to release all relevant medical or treatment records to the independent review organization and/or the Ohio Department of Insurance. I understand that the independent review organization and the Ohio Department of Insurance will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

_____

Signature of Covered Person (or legal representative**) Date

**Parent, Guardian, Conservator or Other - please specify*

Be certain to keep copies of this form, your Notice of Final Adverse Benefit Determination and all documents and correspondence related to this claim.

Treating Physician Certification Form for Internal Appeal and/or External Review

Note to the Treating Physician: Covered Persons may request an internal appeal and/or external review when a health plan issuer has denied a health care service or course of treatment. The standard internal appeal and external review processes can take up to 30 days from the request date to the date a decision is rendered. Expedited appeals or reviews are only available under the circumstances shown below. This form is for the purpose of providing the certification necessary to obtain an expedited appeal or review. Please complete the General Information section along with the appropriate certification and return the executed form to Active Health Management, Inc. at any of the addresses shown below:
Fax Number: 1-855-231-1218
Mailing Address: Active Health Management
GVPRIOR
PO Box 221138
Chantilly, VA 20153-1138

General Information

Name of Covered Person/Patient:
Covered Person's Health Plan ID Number:
Name of Treating Physician:
Licensure and Area of Clinical Specialty:
Mailing Address: Phone Number:
Email Address: Fax Number:
Contact Person: Phone Number:

Expedited Internal Appeal Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard internal appeal would, in my professional judgment, subject the covered person to severe pain that cannot be adequately managed without the requested care or treatment; and that, for this reason, the covered person's appeal should be processed on an expedited basis.
Treating Physician Printed Name: _____

_____
Signature Date

Concurrent Expedited Internal Appeal and Expedited External Review Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); and (select all that apply):

❒ that adherence to the time frame for conducting an expedited internal appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's expedited internal appeal should be conducted simultaneously with an expedited external review.

❒ that the recommended experimental or investigational treatment would, in my professional judgment, be significantly less effective if not promptly initiated; and that, for this reason, the covered person's expedited internal appeal should be conducted simultaneously with an expedited external review. I have attached the completed Treating Physician Certification Form for Experimental/ Investigational Adverse Benefit Determinations.

Treating Physician Printed Name:

_____

Signature Date

Expedited External Review Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard external review would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's external review should be processed on an expedited basis.

Treating Physician Printed Name: _____

_____

Signature Date

Physician Certification for Experimental/Investigational Denial Determinations

Note to the Treating Physician: Covered Persons may request an external review when a health plan issuer has denied a health care service or course of treatment that is considered experimental or investigational and is NOT explicitly listed as an excluded benefit under the covered person's health benefit plan. This form is for the purpose of providing the certification necessary to obtain a review. Please complete the entire form including the certification and return the executed form to Active Health Management, Inc. at any address shown below.

Fax Number: 1-855-231-1218
Mailing Address: Active Health Management
GVPRIOR
PO Box 221138
Chantilly, VA 20153-1138

General Information

Name of Covered Person/Patient:
Covered Person's Health Plan ID Number:
Name of Treating Physician:
Licensure and Area of Clinical Specialty:
Mailing Address: Phone Number:
Email Address: Fax Number:
Contact Person: Phone Number:

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health plan issuer'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:

In my medical opinion as the covered person's treating physician, I hereby certify to the following: (Please check all that apply)

❒Standard health care services have not been effective in improving the condition of the covered person

❒Standard health care services are not medically appropriate for the covered person

❒There is no available standard health care service covered by the health plan issuer that is more beneficial than the requested health care service

Please provide a description of the recommended or requested health care service or treatment that is the subject of the adverse benefit determination. Please include any documentation that will be beneficial to the review process. Please attach additional sheets as necessary.

_____
_____
_____

Treating Physician Printed Name: _____

_____
Signature Date