TEXAS DEPARTMENT OF INSURANCE
Financial Regulation Division - Managed Care Quality Assurance (103-6A)
333 Guadalupe, Austin, Texas 78701 ✯ PO Box 149104, Austin, Texas 78714-9104
(512) 676-6400 | F: (512) 490-1013 | (866) 554-4926 | TDI.texas.gov | @TexasTDI

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)
INSTRUCTIONS

(DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE)

Instructions to Patient, Person Acting on Behalf or Representative of Patient/Employee, and Provider:
This form is being provided to you because your request for health care services has been denied as not medically necessary by your insurance carrier. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier (company). This is called an independent review by an Independent Review Organization or "IRO." You, your health care provider, or someone acting on your behalf or representative may file this form.

To request an independent review of your case, you must take the following action:

- Complete the Request for a Review by an Independent Review Organization form (TDI Form LHL009).
- Sign the form so the IRO can receive your medical records. (A signature is not required for Workers' Compensation cases).
- RETURN THE COMPLETED FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES AS SOON AS POSSIBLE. (For Workers' Compensation cases, you must return this form within 45 calendar days).
    - Carrier instructions: Complete the "Company or URA That Denied Services" Section on page 4.
    - Note to patients: The company address and/or fax number can be found on the denial letter.

The company will forward your request for an independent review to TDI. Once TDI receives the request from the company, TDI will assign your case to an IRO. You will receive a letter from TDI identifying the IRO to whom your case has been assigned. The timeframes for an IRO's decision are as follows:

Coverage Types	Health	Workers' Compensation Network (WCN)	Workers' Compensation Non-Network (WC)
Life Threatening	3 days	8 days	8 days
Denial of Prescription Drugs or Intravenous Infusions - Concurrent	3 days	NA	NA
Denial of an exception request to a prescription drug step therapy protocol - Preauthorization	3 days	NA	NA
Non-Life Threatening Preauthorization/Concurrent	20 days	20 days	20 days
Retrospective	20 days	30 days from receipt of IRO fee*	30 days from receipt of IRO fee**

*Carrier pays the fee.
**Requestor pays the fee. (However, if the requestor is an injured employee, carrier pays the fee.)

There is no cost to you for the independent review. **Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective independent review will be required to pay the IRO fee prior to the IRO beginning its review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.**

REQUEST FORM

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Today's Date: Month_____ Day_____ Year_____

Name of Party Requesting Independent Review: _____ **Print Last Name, First Name and Middle Initial**	**Relationship to the Patient or Injured Employee:** **(Check one)** ☐ Self (complete page 3, item A) ☐ Person acting on behalf of patient or injured employee (complete page 3, items A and C) ☐ Provider acting on behalf of patient or injured employee (complete page 3, items A and B) ☐ Provider that received the denial (complete page 3, item A) ☐ Sub claimant (Workers' Compensation only) (complete page 3, items A and C)

REASON FOR REQUEST FOR REVIEW BY AN IRO

APPLIES TO HEALTH AND WORKERS COMPENSATION CASES:	APPLIES TO HEALTH CASES ONLY:
Is the condition life-threatening? Check one: ☐ Yes ☐ No (This question does not apply if services have been received) Is the review ordered by a Court? Check one: ☐ Yes ☐ No	Is this a denial of prescription drugs or intravenous infusions for which you are already receiving benefits? Check one: ☐ Yes ☐ No Is this a denial of an exception request to a prescription drug step therapy protocol: Check one: ☐ Yes ☐ No

DENIED SERVICES

Describe the health care services that are being denied (include dates only if services have been performed):

_____

_____

PATIENT/INJURED EMPLOYEE INFORMATION

Health Plan or Claim Identification Number:_____

(This number is usually found on the patient's ID card for health plans. The number identifies the patient to the insurance carrier. Enter the DWC claim number for workers' compensation cases.)

Date of Birth:*(month)* _____ *(day)* _____ *(year)*_____ Sex_____

First Name_____Middle Name _____ Last Name _____Suffix_____

Street _____

City_____ State_____ Zip code_____

Phone _____-_____ Fax _____-_____

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES. (DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)

A. PROVIDER THAT RECEIVED THE DENIAL

Name_____

Federal Tax Identification Number _____

Street_____

City_____ ____State_____ Zip code_____

Phone _____-_____ Fax _____-_____

B. **PROVIDER ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF IF APPLICABLE**

Name_____

Federal Tax Identification Number _____

Street_____

City_____ _____State_____ Zip _____

Phone number: _____-_____Fax number: _____-_____

C. PERSON ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF IF APPLICABLE

First Name_____Middle Name _____Last Name _____Suffix_____

Relation to patient _____

Street_____

City_____State_____Zip _____

Phone number _____-_____Fax number _____-_____

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES. (DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)

RELEASE

(The release must be signed by the patient, or his or her parent or legal guardian.)
(NOT REQUIRED FOR WORKERS' COMPENSATION CASES)

I,_____ (**Print last name, first name and middle initial)**, the patient, parent, or patient's legal guardian ***(circle one)***, authorize the release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed_____ Date: *(mo)* _____ *(day)* _____*(yr.)* _____

Note: For chemical dependency or mental health treatment, list the providers to which this release applies:

_____
_____
_____
_____

COMPANY OR UTILIZATION REVIEW AGENT THAT DENIED SERVICES

(This section to be completed ONLY by the company or URA that denied services.)

Name of Company _____

Address _____

City _____ State _____ Zip _____

Toll-Free Number _____ Fax Number _____

The person requesting the independent review should submit this form to the company, as given, in this section. (Do not submit this form to TDI.)

NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES
With few exceptions, you are entitled to be informed about the information the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please contact the Agency Counsel Section of TDI's General Counsel Division at (512) 676-6551 or visit the Corrections Procedure section of TDI's website at www.tdi.texas.gov.

FOR INFORMATION ABOUT THE INDEPENDENT REVIEW PROCESS, PLEASE CALL TDI AT 1-866-554-4926, OPTION 7.

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES. (DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)