Pennsylvania Insurance Department

Request for Independent External Review of an Adverse Benefit Determination

Applications can also be completed online at: www.insurance.pa.gov/externalreview

Member Information

Member Name: _____ Date of Birth: _____

Name of Member's Legal Guardian (if applicable): _____

Address of Member (or Legal Guardian): _____

_____

_____

Phone Number(s): _____

Email: _____

☐ **By selecting this box, I agree to receive electronic notices.**

Health Insurance Plan Information

Name of Insurer: _____

Health Insurance Plan: _____

Insurer NAIC Number: _____

Subscriber or Member ID Number: _____

Insurance Claim/Reference Number: _____

Health Care Decision in Dispute

Date of Insurer Decision: _____

Service Denied: _____

Do you or your doctor think this was a medical emergency? ☐ Yes ☐ No

***If yes, have your provider complete the physician certification and include with request**

If any of your health care providers will be involved with this external review, please complete the following section:

Name of Health Care Provider: _____

Type of Provider: ☐Medical Doctor ☐Other (Please Specify): _____

Provider Mailing Address: _____

_____

_____

Provider Phone Number: _____

Describe your insurer's decision in your own words. Include whatever information you have about dates, names of health care providers, and details about the service(s) being denied. Explain why you disagree with the insurer. Attach additional pages if necessary.

Member Representation

Fill Out This Section If Someone Will Be Representing You In This Appeal

You can have a family member, friend, lawyer, or other person represent you or act on your behalf. You or your representative may ask your insurer to see any information your insurer has about the medical service(s) that is the subject of your external review.

Send member: ☐Correspondence ☐Medical Records and Other

Send Representative: ☐Correspondence ☐Medical Records and Other

I hereby authorize _____ to pursue this external review on my behalf and not (by this authorization) for any other purpose.

Representative's Address: _____

_____

_____

Representatives Primary Phone Number: _____

Secondary Phone Number: _____

Email: _____

☐ By selecting this box, I agree for my representative to receive electronic notices.

Pennsylvania Insurance Department

Consent to Release and Exchange Information

I, _____, hereby request an external review of an adverse benefit determination and authorize the Pennsylvania Insurance Department to obtain copies of my medical records and all other information necessary for this review. The Department has my permission to release and exchange this information with my health insurer and an independent review organization certified by the Department, and with any health care provider or personal representative designated on this application form.

☐In addition, though I do not have a representative, I want the Department to be able to release and exchange all information related to this review with:

_____

_____ _____

Signature of Member or Legal Guardian Date

Filing Instructions

Applications for External Review may be completed online at:

www.insurance.pa.gov/externalreview

Completed applications and any supporting information may be submitted by:

Faxing to: 717-231-7960

Emailing to: RA-IN-ExternalReview@pa.gov

Mailing to: Pennsylvania Insurance Department
Attn: Bureau of Health Coverage Access, Administration, and Appeals
1311 Strawberry Square
Harrisburg, PA 17120