STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

Return Request to:
CONNECTICUT INSURANCE DEPT
Attn: External Review
P.O. Box 816 • Hartford, CT 06142-0816

For Overnight Mail Only:
CONNECTICUT INSURANCE DEPT
Attn: External Review
153 Market Street • Hartford, CT 06103

Telephone: 1-860-297-3910 **Fax:** 1-860-297-3872 **Email**: externalreview@ct.gov

*Indicates required field

APPLICANT *(Person requesting the external review)* Applicant must be 18 years or older

*Applicant Name: _____

*Applicant Address: _____

*Applicant Daytime Telephone #: _____ E-mail: _____

*Applicant Type: ◯ Enrollee/Patient ◯ Parent of Minor Child under 18 ◯ Authorized Representative *(See page 2)*

PATIENT/ENROLLEE *(Person for whom a requested service or treatment was denied)*

*Patient Name: _____ * DOB: _____

*Patient Address: _____

*Patient Telephone #: _____

INSURANCE INFORMATION

* Insurance Company/Health Plan Name: _____

Subscriber Name: _____

* Insurance ID #: _____

Coverage Type: ◯ Individual Plan

◯ Group Plan - Employer Name: _____

HEALTH CARE PROVIDER INFORMATION

Treating Healthcare Provider: _____

Address: _____

Contact Person: _____

E-mail: _____ Telephone #: _____ Extension: _____

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*Indicates required field

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

Complete only if the applicant is other than patient or parent of a minor child.

I appoint _____ to act as my authorized representative for the purposes of section 38a-591g of the Connecticut General statutes, dealing with external review of final adverse determinations for medical necessity.

I authorize _____ to make any request; to present or to elicit evidence; to obtain review information; and to receive any notice in connection with my review, wholly in my stead. I understand that personal medical information related to my review may be disclosed to the representative indicated.

Signature of Patient (parent if patient is under 18 years old) Or Legal Representative with legal authorization attached	**Relationship** (If other than patient)	**Date**

This designation will expire one (1) year from the date it was signed, upon revocation or upon a final determination being rendered upon the action, whichever occurs sooner. Upon expiration, a new designation must be written in order to be valid. You may cancel this designation in writing at any time.

REASON FOR THE APPEAL

* ◯ Pre-service denial ◯ I am currently in treatment ◯ Post-service denial

Please indicate the type of service or treatment being denied and the specific date(s) of service. Attach additional pages if necessary. You will need to attach a copy of the final denial letter from the health plan with your application.

_____

_____

_____

* Copy of Final Denial Letter Attached

***EXPEDITED REVIEW** ◯ Yes ◯ No *Not available if services have already been received.*

* To qualify for an expedited review, your physician must sign the Physician Certification Form certifying that the standard time frames for review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. (Behavioral health or substance abuse denials do not require a Physician Certification Form.)

◯ Physician Certification Form Attached

-OR-

◯ Behavioral Health or Substance Abuse Denial

- No Physician Certification needed - automatically expedited

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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 health benefit plan.

*		
Signature of Patient (parent if patient is under 18 years old) Or Legal Representative with legal authorization attached	**Relationship** (If other than patient)	**Date**

SUBMISSION INSTRUCTIONS

MAILING INSTRUCTIONS:
Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford CT 06142-0816

For Overnight Delivery Only:
Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford CT 06103

THE FOLLOWING ITEMS MUST BE SUBMITTED: Your request will not be processed without these items.

- ✓ Application - Completed and Signed
- ✓ Copy of ID Card
- ✓ Copy of Final Denial Letter
- ✓ Physician Certification Form (if expedited)

Filing Deadline - You have 120 days to file your external review after receipt of the final internal appeal denial letter.

Expedited External Review - Expedited requests may be filed immediately following receipt of any denial of service without completing the health plan's appeal process.

Additional New Medical Information - Please be sure to submit any additional documentation to support your request for approval of the denied services or treatment. You may ask your treating physician to provide information to support your External Review.

Need assistance? Please call our Consumer Affairs Division at 1-860-297-3910.

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*Only return this completed form for **expedited** External Review Requests.*

PHYSICIAN CERTIFICATION FORM
Expedited Request

Notice to Treating Health Care Provider

The enrollee/patient listed above has requested an external review because the 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, or effectiveness of the health care service.

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.

Please Note:

- Expedited reviews are only available if services have not yet been rendered.
- External Reviews for a denial of services related to a behavioral health or substance abuse will automatically be expedited and do not require this form.

NAME OF ENROLLEE/PATIENT: _____

SERVICE OR TREATMENT THAT HAS BEEN DENIED: _____

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* I certify that I am the treating physician; that adherence to the time frame for conducting a standard external review for the above-named patient would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and for this reason, the patient's appeal of the denial by the health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____	_____	_____
Physician Signature	**State Medical License #**	**Date**

Name of Treating Physician: _____

Physician Address: _____

_____

*Only return this completed form for **expedited** External Review Requests.*