EXTERNAL REVIEW REQUEST FORM

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:

Continued on reverse side

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 Georgia Department of Insurance. I understand that the independent review organization and the Georgia 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 free of charge.

_____

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

*Parent, Guardian, Conservator or Other - please specify

SEND THIS FORM AND A COPY OF YOUR NOTICE OF FINAL ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING ADDRESSES:

Fax Number: 844-676-0366

Website: **CareSource.com**

Mailing Address: CareSource, Attn: Member Appeals, PO Box 1947, Dayton, OH 45401

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

If you need help with this form, please call our Member Services department at **1-833-230-2030**, Monday through Friday, 7 a.m. to 7 p.m.

GA-EXCM-0165