A Qualified Health Plan Issuer on the Health Insurance Marketplace

P.O. Box 8738, Dayton, OH 45401-8738 | CareSource.com

EXTERNAL REVIEW REQUEST FORM (Indiana)

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. Are you requesting an Expedited External Review because review under the standard External Review **time frame (of up to 15 business days) could, in the absence of immediate medical attention, result in placing your life or health in serious jeopardy, seriously jeopardize your ability to reach and maintain** maximum function, or your External Review is related to a claim involving an Emergent Care and a Concurrent Care Claim?

   ❒YES* ❒NO

***If you answer YES to the above question, your treating provider should complete the Treating Provider Opinion Form for Internal Appeal and/or External Review.**

2. Are you requesting an Expedited External Review because the health care service in question would be significantly less effective if not promptly initiated?
   ❒YES* ❒NO

***If you answer YES to the above question, your treating provider must complete the Treating Provider Opinion Form for Internal Appeal and/or External Review.**

Briefly describe why you disagree with the Final Adverse Benefit Determination (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 External Review)

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**, [Insert Name of Member**]_____, appoint **[Insert Name of Authorized**

Representative]_____**,** to act on my behalf in connection with any claim for coverage or benefits identified in this case, including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me and to provide any information to the health plan in relation to the disputed claims, approvals, or authorizations.

_____

Signature of Covered Person (or legal representative*) Date

*Parent, Guardian, Conservator, Other—please specify

I,**[Insert Name of Authorized Representative]**_____**,** hereby accept the above

appointment. I am a/an [**Insert Relationship to Member**]_____.

_____

Signature of Authorized Representative Date

Consent to Release Medical Records

To request an External Review of your Final Adverse Benefit Determination, you must sign and date this form and consent to the release of your medical records. If you are requesting an Expedited External Review of your Final Adverse Benefit Determination, you may first submit an oral request. Then, you must submit this form to CareSource.

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, the Indiana Department of Insurance, and/or my health plan issuer. I understand that the Independent Review Organization 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. 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

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

Fax Number: 1-866-582-0613

Email Address: HIXING&A@caresource.com

Mailing Address: CareSource Attn: Grievance & Appeals, P.O. Box 1947, Dayton, OH 45401-1947

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 1-877-806-9284, from 7:00 a.m. to 7:00 p.m., Monday through Friday.

IN-EXCM-0015a