A Qualified Health Plan Issuer on the Health Insurance Marketplace
P.O. Box 8738, Dayton, OH 45401-8738 | CareSource.com

EXTERNAL REVIEW REQUEST FORM (Kentucky)

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 you are currently hospitalized?
   ❒YES* ❒NO

If you answer YES, then your provider must complete the Treating Provider Opinion Form for Internal Appeal and/or External Review.

2. Are you requesting an Expedited External Review because in the opinion of your treating provider, review under the standard External Review time frame (of up to 45 days) could, in the absence of immediate medical attention, result in placing your health or the health of your unborn child in serious jeopardy, cause serious impairment of your bodily functions, or cause you serious dysfunction of a bodily organ or part?

   ❒YES* ❒NO

If you answer YES, then your provider must complete the Treating Provider Opinion Form for Internal Appeal and/or External Review.

3. Are you requesting an Expedited External Review because your requested health care service is considered an experimental or investigational treatment?

   ❒YES* ❒NO

If you answer YES, then your provider must complete the Treating Provider Opinion Form 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 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 Entity, the Kentucky Department of Insurance, and/or my health plan issuer. I understand that the Independent Review Entity 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: 866-582-0614

Email Address: MarketplaceKentuckyClaimsFax@CareSource.com

Mailing Address: CareSource, Attn: Member Appeals, P.O. 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.

KY-EXCM-0021a