EXTERNAL REVIEW OF A DRUG EXCEPTION BY INDEPENDENT REVIEW ENTITY

If we deny your request for an Exception to a Formulary Drug in an Internal Review and you receive a denial from us, you may complete this form to ask for an External Review of our decision. An external review will be done by an Independent Reviewer contracted by us to review the denial.

You may find this form online at CareSource.com/marketplace. It is located under Members in the Tools & Resources menu, under Forms.

Name of person asking for an External Review: _____

Relationship to covered person: ❒**Covered Person/Applicant**

❒**Authorized Representative (please complete the Appointment of Authorized Representative section on page 2)**

Authorization ID#: _____ **Denial Date:** _____

Priority: ❒ **Standard** ❒ **Expedited (if Expedited is checked, Provider must fill out certification below)**

I certify that a delay in the patient's requested service for the standard appeal time period is likely to seriously endanger the patient's life, health, or ability to regain maximum fu**nction, or have a significant negative effect on their medical condition, or subject the patient to severe pain that cannot be adequately managed without the requested service.**

Provider's Signature: _____ Date: _____

Printed Name: _____

Covered Person/Applicant Information

Name: **CareSource ID Number:**

Mailing Address:

Daytime Phone: **Evening Phone:**

Email Address: **Fax:**

Prescribing Provider Information

Name:

Mailing Address: **Phone Number:**

Email Address: **Fax Number:**

Contact Person: **Phone Number:**

Tell us why you disagree with our decision about your request for an Exception (you may attach more information, like a provider's letter, bills, medical records, or other documents to support your claim):

_____

_____

_____

_____

Appointment of Authorized Representative Complete this section if someone else is representing you in this External Review.

You may ask for this review yourself, or you may ask another person to represent you. This may include your treating provider. You may cancel this authorization at any time.

I, (Name of Member)_____, appoint (Name of Authorized

Representative)_____, to represent me on any claim for coverage or benefits in this case, including any approvals or authorizations that are needed before medical services. My representative should have any and all information about this case that is given to me. My representative will give any information needed to the health plan about the disputed claims, approvals, or authorizations.

_____

Signature of Covered Person (or legal representative*) Date
***Parent, Guardian, Other—please specify**

I, (Name of Representative)_____, accept the above

appointment. I am a/an (Relationship to Member)_____.

_____

Signature of Authorized Representative Date

Contact information of representative (if needed)

Mailing Address:

Daytime Phone: **Evening Phone:**

Email Address: **Fax:**

Consent to Release Medical Records

To ask for an External Review of our decision, you must sign and date this form and agree to the release of your medical records.

I, _____, request an External Review. I verify that the information given on this form is true and correct to the best of my knowledge. I authorize my treating provider and health plan issuer to release all related records to the Independent Reviewer, the Department of Insurance, and my health plan issuer. I understand that the Independent Reviewer will use this information to make a decision about my External Review. This information will be kept confidential and will not be given to anyone else. I understand that I or my representative may have 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 DRUG EXCEPTION DETERMINATION TO ONE OF THE BELOW:

MyCareSource.com Member Portal – or – ProviderPortal.CareSource.com Provider Portal

Or

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

Be sure to keep copies of:

- **this form**
- **Notice of Initial Review Determination**
- **all related documents and correspondence**

If you need help with this form or your request, please call Member Services at 1-833-230-2099 (TTY: 711). Providers can call 1-833-230-2101 with questions.

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