

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the External Review Division, Arkansas Insurance Commissioner 1200 West Third Street, Little Rock, AR 72201; within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment.

## EXTERNAL REVIEW REQUEST FORM

### APPLICANT INFORMATION

Applicant Name \_\_\_\_\_

- Covered person/Patient
- Provider
- Authorized Representative

### COVERED PERSON/PATIENT INFORMATION

Covered Person Name \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

Covered Person Phone No. Home \_\_\_\_\_ Work \_\_\_\_\_

### INSURANCE INFORMATION

Insurer/HMO Name \_\_\_\_\_

Covered Person Insurance ID No. \_\_\_\_\_

Insurance Claim/Reference No. \_\_\_\_\_

Insurer/HMO Mailing Address \_\_\_\_\_

Insurer Telephone No. \_\_\_\_\_

### EMPLOYER INFORMATION

Employer's Name \_\_\_\_\_

Employer's Phone No. \_\_\_\_\_

- Yes  No Is the health coverage you have through your employer a self-funded plan?  
If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

### HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider \_\_\_\_\_

Address \_\_\_\_\_

Contact Person \_\_\_\_\_

Phone No. \_\_\_\_\_ Medical Record No. \_\_\_\_\_

### REASON FOR HEALTH CARRIER DENIAL (Please check one)

- The health care service or treatment is not medically necessary.
- The health care service or treatment is experimental or investigational.

**SUMMARY OF EXTERNAL REVIEW REQUEST**

Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier. You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

**EXPEDITED REVIEW**

**If you need a fast decision**, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function.

Yes  No Is this a request for an expedited appeal?

**SIGNATURE AND RELEASE OF MEDICAL RECORDS**

To appeal your health carrier’s denial, you must sign and date this external review request form and consent to the release of medical records.

I, \_\_\_\_\_, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Arkansas Insurance Department. I understand that the independent review organization and the Arkansas Insurance Department will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

\_\_\_\_\_  
Signature of Covered Person (or legal representative)\*

\_\_\_\_\_  
Date (MM/DD/YYYY)

If signed by legal representative:

- Parent
- Guardian
- Conservator
- Other. Please Specify: \_\_\_\_\_

**APPOINTMENT OF AUTHORIZED REPRESENTATIVE**

**Fill out this section only if someone else will be representing you in this appeal.**

You can 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 appeal on my behalf.

\_\_\_\_\_  
Signature of Covered Person (or legal representative)\*

\_\_\_\_\_  
Date (MM/DD/YYYY)

**If signed by legal representative:**

- Parent
- Guardian
- Conservator
- Other. Please Specify: \_\_\_\_\_

**Address of Authorized Representative:**

\_\_\_\_\_  
Address City State Zip

Daytime phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

**HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE**

Describe in your own words the disagreement with your health carrier. Indicate clearly the service(s) being denied and the specific date(s) being denied. Explain why you disagree. Attach additional pages if necessary and include available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies, and any additional information from your physician/health care provider that you want the independent review organization reviewer to consider.

**WHAT TO SEND AND WHERE TO SEND IT**

Please check below.

**Note: Your request will not be accepted for full review unless all four (4) items below are included\* .**

- YES**, I have included this completed application form signed and dated.
- YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
- YES\*\***, I have enclosed the letter from my health carrier or utilization review company that states:
  - Their decision is final and that I have exhausted all internal review procedures; or
  - They have waived the requirement to exhaust all of the health carrier’s internal review procedures.

\*\*You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact:

External Review Division  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201  
Phone: 1.800.282.9134.

- YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

\*Call the Insurance Department at 1.800.282.9134 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to:

External Review Division  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201.

**If you are requesting an expedited external review, call the Arkansas Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.**

**CERTIFICATION OF TREATING HEALTH CARE PROVIDER  
FOR EXPEDITED CONSIDERATION OF A PATIENT’S EXTERNAL REVIEW APPEAL**

**NOTE TO THE TREATING HEALTH CARE PROVIDER**

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment 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 or treatment you requested. The External Review Division of the Arkansas Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date the patient’s request for external review is received by our department. Expedited external review is available only if the patient’s treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

**GENERAL INFORMATION**

Name of Treating Health Care Provider \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Fax Number \_\_\_\_\_  
Licensure and Area of Clinical Specialty \_\_\_\_\_  
Name of Patient \_\_\_\_\_  
Patient’s Insurer Member ID No. \_\_\_\_\_

**CERTIFICATION**

I hereby certify that: I am a treating health care provider for \_\_\_\_\_ (hereafter referred to as “the patient”); that adherence to the time frame for conducting a standard external review of the patient’s appeal 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 that, for this reason, the patient’s appeal of the denial by the patient’s health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider’s Name (Please Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date (MM/DD/YYYY) \_\_\_\_\_

**PHYSICIAN CERTIFICATION — EXPERIMENTAL/INVESTIGATIONAL DENIALS**

**(To Be Completed by Treating Physician)**

I hereby certify that I am the treating physician for \_\_\_\_\_  
(covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

**In my medical opinion as the Insured's treating physician, I hereby certify to the following. Please check all that apply. NOTE:** Requirements #1 - #3 below must all apply for the covered person to qualify for an external review.

1. The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.
2. The covered person has a condition that qualifies under one or more of the following - [please indicate which description(s) apply]:
  - Standard health care services or treatments have not been effective in improving the covered person's condition;
  - Standard health care services or treatments are not medically appropriate for the covered person;
  - There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.
3. The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.
4. The health care service or treatment recommended would be significantly less effective if not promptly initiated.  
Explain:

5. It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.  
Explain:

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

## Non-Discrimination and Accessibility Notice

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (501) 228-7111. If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

QualChoice Civil Rights Coordinator  
QualChoice  
P.O. Box 25610  
Little Rock, AR 72221-5610  
(501) 228-7111  
Fax #: 501-707-6729  
QCA\_COE@qualchoice.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the QualChoice Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Notice of Discrimination Grievance Procedures

It is the policy of QualChoice not to discriminate on the basis of race, color, national origin, sex, age or disability. QualChoice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated to coordinate the efforts of QualChoice to comply with Section 1557 (the "Section 1557 Coordinator"):

QualChoice Civil Rights Coordinator  
QualChoice  
P.O. Box 25610  
Little Rock, AR 72221-5610  
(501) 228-7111  
Fax #: 501-707-6729  
QCA\_COE@qualchoice.com

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for QualChoice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of QualChoice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice President Corporate Responsibility within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The Vice President Corporate Responsibility shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.



The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination. QualChoice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

**QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government. ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-800-235-7111 (TTY: 711).**

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese

LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbāl in jipañ ilo kajin ñe am ejjelōk wōñāān. Kaalōk 1-800-235-7111 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711)。

Lao

ໂປດຊາວລາວ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-235-7111 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-7111 (رقم هاتف الصم والبكم: 117).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-235-7111 (TTY: 711) まで、お電話にてご連絡ください。

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).