STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

Return Request to:
CONNECTICUT INSURANCE DEPT
Attn: External Review
P.O. Box 816 • Hartford, CT 06142-0816

For Overnight Mail Only:
CONNECTICUT INSURANCE DEPT
Attn: External Review
280 Trumbull Street • Hartford, CT 06103

Telephone: 860-297-3910 **Fax:** 860-297-3872 **Email**: externalreview@ct.gov

THIS PAGE MUST BE SIGNED BY THE PATIENT IF SOMEONE OTHER THAN THE PATIENT IS THE APPLICANT.

A covered person, a covered person's authorized representative or healthcare provider may file a request for an external review of an adverse determination. Please sign the authorization below if you choose to have an authorized representative or healthcare provider act on your behalf.

*Indicates required field

APPLICANT *(Person requesting the external review)* Applicant must be 18 years or older

* Applicant Type: ◯ Enrollee/Patient ◯ Parent of Minor under 18 ◯ Healthcare Provider ◯ Authorized Representative

*Applicant Name: _____

*Applicant Address: _____

*Applicant Daytime Telephone #: _____ Email: _____

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

Must be completed if the applicant is someone other than patient.

I appoint _____ to act as my authorized representative for the purposes of section 38a-591g of the Connecticut General statutes, dealing with external review of final adverse determinations for medical necessity.

I authorize _____ to make any request; to present or to elicit evidence; to obtain review information; and to receive any notice in connection with my review, wholly in my stead. I understand that personal medical information related to my review may be disclosed to the representative indicated.

_____	_____	_____
Signature of Patient (parent if patient is under 18 years old) Or Legal Representative with legal authorization attached	**Relationship**	**Date**

This designation will expire one (1) year from the date it was signed, upon revocation or upon a final determination being rendered upon the action, whichever occurs sooner. Upon expiration, a new designation must be written in order to be valid. You may cancel this designation in writing at any time.

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

*Indicates required field

PATIENT/ENROLLEE *(Person for whom a requested service or treatment was denied)*

*Patient Name: _____ * DOB: _____

*Patient Address: _____

*Patient Telephone #: _____

Patient Email Address: _____

INSURANCE INFORMATION

* Insurance Company/Health Plan Name: _____

* Subscriber Name: _____

* Insurance ID #: _____

Coverage Type: ◯ Individual Plan

◯ Group Plan - Employer Name: _____

HEALTH CARE PROVIDER INFORMATION

Treating Healthcare Provider: _____

Address: _____

Contact Person: _____

Email: _____ Telephone #: _____ Fax: _____

REASON FOR THE APPEAL

* ◯ Pre-service denial ◯ I am currently in treatment ◯ Post-service denial

Please indicate the type of service or treatment being denied and the specific date(s) of service. Attach additional pages if necessary. A copy of the final denial letter from the health plan is required with your application.

EXPEDITED REVIEW ◯ Yes ◯ No *Not available if services have already been received.*

* To qualify for an expedited review, your physician must certify that the standard time frames for review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. (Behavioral health or substance abuse denials do not require the Expedited External Review Form.)

◯ Expedited External Review Form Attached

-OR-

◯ Behavioral Health or Substance Abuse Denial

- No Expedited External Review Form needed - automatically expedited

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

*Indicates required field

CONSENT FOR EXTERNAL REVIEW and RELEASE of MEDICAL RECORDS

I, _____ hereby authorize the release of medical records necessary for the external review. I understand that these records may be obtained from the insurance company/health plan, the utilization review company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this external review and may be viewed by an auditor of the Insurance Department for quality review and examination of record purposes.

I understand that by providing my email address I consent to receiving communications on an electronic basis in relation to this request from the Connecticut Insurance Department and the designated review entity. Any communications containing personally identifiable information, including medical information, are protected by state and federal privacy laws.

I understand that the decision of the independent review organization is binding and that neither the Commissioner nor the Independent Review Organization may authorize services in excess of those covered by my health benefit plan.

*

_____	_____	_____
Signature of Patient (parent if patient is under 18 years old) with legal authorization attached	**Relationship Or Legal Representative** (If other than patient)	**Date**

SUBMISSION INSTRUCTIONS

MAILING INSTRUCTIONS:
Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford CT 06142-0816

For Overnight Delivery Only:
Connecticut Insurance Department
Attn: External Review
280 Trumbull Street, 7th Floor
Hartford CT 06103

THE FOLLOWING ITEMS MUST BE SUBMITTED: Your request will not be processed without these items.

- ✓ Application - Completed and Signed
- ✓ Copy of ID Card
- ✓ Copy of Final Denial Letter

Filing Deadline - You have 120 days to file your external review after receipt of the final internal appeal denial letter.

Expedited External Review - Expedited requests may be filed immediately following receipt of any denial of service without completing the health plan's appeal process.

Additional New Medical Information - Please be sure to submit any additional documentation to support your request for approval of the denied services or treatment. You may ask your treating physician to provide information to support your External Review.

Need assistance? Please call our Consumer Affairs Division at 860-297-3910.

REQUEST FOR EXTERNAL REVIEW

*Only required for **expedited** External Review Requests.*

Expedited External Review Form

Notice to Treating Health Care Provider

In order for the covered person to obtain an expedited external review, the patient's treating health care provider must certify that the standard external review process of 45 days would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

Please Note:

- Expedited reviews are not available for services that have already been received.
- External Reviews for a denial of services related to behavioral health or substance abuse will automatically be expedited and do not require this form.

Patient/Enrollee Name: _____

Explain the nature of the serious and immediate threat to the health of the patient:

I certify that I am the treating physician; that adherence to the time frame for conducting a standard external review for the above-named patient 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 for this reason, the patient's appeal of the denial by the health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

I hereby certify that all of the information provided on this form and any and all supporting documentation I provide is complete and accurate to the best of my knowledge. I understand that intentionally providing false information or making false statements may be grounds for denial of the application, subject to administrative action, and may be punishable by law.

Physician Signature	State Medical License #	Date
_____	_____	_____

Name of Treating Physician: _____

Physician Address: _____

_____

*Only required for **expedited** External Review Requests*