External Review Request Form

POWERED BY
Collective Health

If you are not satisfied with the outcome of your internal appeal, you may have the right to review by an independent review organization (IRO). An IRO can review the following types of determinations:

- Denials based on medical necessity or clinical reasons
- Exclusions for experimental, investigational, or unproven services
- Rescissions of coverage
- Whether the plan is complying with the non-quantitative treatment limitation provisions under certain federal laws or the surprise billing and cost-sharing protections set forth in the No-Surprises Act; or
- As otherwise required by applicable law

We must receive this completed form within the time frame required by the plan.

Claimant Name _______________ Claimant DOB _______________

Subscriber Name _______________ Subscriber ID _______________

Address (email, fax mail) to communicate updates regarding review and any determinations _______________

Services in dispute

Claim Number (if applicable) _______________

Have you already received these services? ☐ Yes Date: _______________ ☐ No

Please state the reason you believe the decision was incorrect (you may also attach a letter of explanation):

____

____

Expedited External Review

If the appeal involves a medical condition(s) where the standard review timeline would seriously jeopardize the patient's life, health, or ability to regain maximum function, or its an emergency service and the patient has not yet been discharged from the medical facility, you may request an expedited review.

Are you requesting an expedited review? ☐ Yes ☐ No

If yes, please provide the following information along with this form, or contact Collective Health with this additional information:

- Confirmation from your doctor that the request qualifies for expedited review
- Confirmation that an expedited internal appeal was also request OR confirmation that you have already exhausted your internal appeals process

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In addition to this form, please submit any additional supporting documentation.
This may include:

- Physicians letters and reports
- Medical records
- Prior authorizations / request for prior authorizations
- Previous appeals letters & rendered determinations

Signature   Date (mm/dd/yyyy)

I am the: ☐ Patient/Subscriber ☐ Parent/Legal Guardian ☐ Authorized Representation

*If you are a third party, a provider, or you are submitting this on behalf of a family member for whom you do not have full PHI authorization, please also fill out the appointment of authorized representative form attached.