Vermont Department of Financial Regulation

REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF A HEALTHCARE DECISION

PATIENT INFORMATION

Patient Name _____

Patient's Legal Guardian *(if applicable)* _____

Address *(for Patient or Legal Guardian)* _____

Please Include Street Address _____

Phone Number *Daytime* _____ Evening _____

COMPLETE THIS SECTION ONLY IF SOMEONE ELSE WILL REPRESENT YOU IN THIS APPEAL.
You can represent yourself or ask another person to make your appeal for you, acting as your personal representative. If you choose to use a personal representative, please provide the name and contact information for this individual. Sign the authorization for that person to act on your behalf.
NOTE: You may revoke this authorization at any time.

Send to **patient:** ☐ Correspondence ☐ Medical records & other attachments

Send to **representative:** ☐ Correspondence ☐ Medical records & other attachments

I hereby authorize _____ to pursue this appeal on my behalf and not (by this
(Name of Personal Representative)
authorization) for any other purpose.

_____ _____
Signature of Patient *(or Legal Guardian)* Date

Representative's Mailing Address *(including Street Address)*

_____
_____
_____

Representative's Phone Number *Daytime* _____ *Evening* _____

COMPLETE THIS SECTION IF YOU WANT TO HAVE A TELEPHONE CONFERENCE.
If you (and your healthcare provider, if desired) want to discuss your case with the independent review organization and your insurer via telephone conference, select the appropriate box below.

◯ Yes. I want a phone conference.

◯ No. I do not want a phone conference. I understand this means the reviewer will base the decision on written information only.

Health Insurance Plan Information

Insurance Carrier Name _____
Health Insurance Plan Contact *(person involved with your appeal)* _____
Insurer Mailing Address _____
_____
_____
Insurer Phone Number *(include area code)* _____
Subscriber or Member No. _____ Insurance Claim/Reference No. _____

SEE OTHER SIDE

HEALTHCARE DECISION IN DISPUTE

Describe your insurer's decision in your own words. Include whatever information you have about dates, names of health care providers and details about the services being denied. Explain why you disagree with the insurer. Attach additional pages if necessary.

Do you or your doctor think this is a medical emergency? ◯ Yes ◯ No

If any of your healthcare provider(s) will be involved with this appeal, please complete the following:

Healthcare Provider Name _____

Provider Type ◯ Doctor ◯ Other *(please specify)* _____

Provider Mailing Address _____

_____

_____

Provider Phone Number _____

CONSENT TO RELEASE AND EXCHANGE INFORMATION

I, _____ hereby request independent external review and authorize the Department of Financial Regulation to obtain copies of my medical records and all other information necessary for this review. The Department has my permission to release and exchange this information with my health insurer and an independent review organization on contract to the Department, and with any healthcare provider or personal representative designated on this application form.

☐ I do not have a representative; however, I authorize the Department to release and exchange all information related to this review with _____

(full name of individual or institution, etc.)

_____ _____

Signature of Patient *(or Legal Guardian, if applicable)* Date

REQUEST TO REDUCE OR WAIVE FILING FEE

I have a financial hardship and cannot pay the $25.00 filing fee:

◯ I am eligible for unemployment assistance, fuel assistance, food stamps, WIC, SSI, TANF, General Assistance, Medicaid or another state or federal assistance program.

◯ I am not eligible for state or federal assistance programs, but I have a financial hardship due to:

_____

WHAT TO SEND AND WHERE TO SEND IT

- **This completed application form.** Call the DFR at **800-631-7788** for assistance with this application.
- **A copy of the health insurer's letter** denying your request at the final level of its appeals process.
- **A check or money order** in the amount of $25.00, payable to the **Department of Financial Regulation.** Do not send a check or money order if you completed the above *Request To Reduce Or Waive Filing Fee*.

Send all paperwork to:

Sebastian Arduengo, Asst. General Counsel
VERMONT DEPARTMENT OF FINANCIAL REGULATION
89 Main St. • Montpelier, VT • 05602-3101