Vermont Department of Financial Regulation

REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF A HEALTH CARE DECISION

PATIENT INFORMATION

Patient's Name: ______________________________

Name of Patient's Legal Guardian (if applicable): ______________________________

Address for Patient (or Legal Guardian): ______________________________

****Please include Street Address* ______________________________

Phone Number: Daytime: ____________________ **Evening:** ____________________

FILL OUT THIS SECTION ONLY IF SOMEBODY ELSE WILL REPRESENT YOU IN THIS APPEAL

You can represent yourself, or you may ask another person to make your appeal for you, acting as your personal representative. If you choose to do this, tell us who is representing you and sign the authorization for that person to act for you. NOTE: You may revoke this authorization at any time.

Please send **patient**: ❐ correspondence ❐ medical records & other

Send **representative**: ❐ correspondence ❐ medical records & other

I hereby authorize ______________________________ to pursue this appeal on my behalf and not (by this authorization) for any other purpose.

(Name of Personal Representative, if one used)

______________________________ ____________________

Signature of Patient (or Legal Guardian if applicable) Date

Representative's Mailing Address (including Street Address):

____

____

____

Representative's Phone Number: Daytime: ____________________ **Evening:** ____________________

FILL OUT THIS SECTION IF YOU WANT TO HAVE A TELEPHONE CONFERENCE

If you think you (and, if you wish, your health care provider) might want to discuss your case with the independent review organization and your insurer in a telephone conference, please request it now.

❐ **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 the written information only.**

HEALTH INSURANCE PLAN INFORMATION

Name of Insurer: ______________________________

Person at Health Insurance Plan involved with your appeal: ______________________________

Insurer Mailing Address: ______________________________

____

Insurer Area Code and Phone Number: ______________________________

Subscriber or Member Number: ____________________ **Insurance Claim/Reference Number:** ____________________

SEE OTHER SIDE

HEALTH CARE 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 health care provider(s) will be involved with this appeal, please complete the next section:

Name of Health Care Provider: ______________________________

Type of Provider: ❒ **medical 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 health care provider or personal representative designated on this application form.

❒ I do not have a representative but I want the Department to be able to release and exchange all information related to this review with

______________________________.

______________________________ ____________________

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 because:

WHAT TO SEND AND WHERE TO SEND IT

❒ **This completed application form.** Call the Department at **802-828-0184** if you need help with this application.

❒ **A copy of the letter from your health insurer,** denying your request at the final level of their 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: E. Sebastian Arduengo
Director External Appeals Program
Vermont Department of Financial Regulation
89 Main St.
Montpelier, VT 05602-3101