REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Today's date: Month______________ Day______________ Year______________

Name of Party Requesting the Independent Review:	Relationship to the Patient:
______________________________________	______________________________________
Patient *(Last Name) (First Name) (Middle Initial)*	*(i.e., self, person acting on behalf of the patient, healthcare provider)*

Reason For Request For Review By An Independent Review Organization: *(check only one)*

1) ☐ The Utilization Review Agent's Internal Appeal Process has been completed and I request its determination be reviewed by an Independent Review Organization.

2) ☐ I am appealing the initial determination of the Utilization Review Agent to an Independent Review Organization because the patient has a Life Threatening Condition.

3) ☐ As ordered by the court, I am requesting review by an Independent Review Organization.

Provider of Record:

Name:____

Street:____

City:__________________________ State:____________________ Zip:________________

Phone number: ________-______________ Fax number: ________-______________ (if applicable)
(area code) (number) (area code) (number)

PROVIDER OF RECORD - The physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the patient and includes any health care facility when treatment is rendered on an inpatient or outpatient basis.

Patient:

Health Plan Identification Number________________ Identification Number______________________
(The unique number which identifies the patient's Health Plan) (The unique number which identifies the patient to the Health Plan)
(These numbers are typically on the patient's ID card.)

Patient's Date of Birth *(month)*____ *(day)*_____ *(year)*_____ Sex_____ Social Security Number____________

Name:______________________________ Street:______________________________

City:__________________________ State:____________________ Zip Code:______________

Phone number: ________-______________ Fax number: ________-______________ (if applicable)
(area code) (number) (area code) (number)

Person or Provider Acting On Patient's Behalf *(if applicable)*

Name:__________________________ If a provider, Federal Tax Identification Number:______________

Street:____

City:__________________________ State:____________________ Zip Code:______________

Phone number: ________-______________ Fax number: ________-______________ (if applicable)
(area code) (number) (area code) (number)

(THE RELEASE MUST BE SIGNED BY THE PATIENT, or his or her LEGAL GUARDIAN)

I, ______________________________, the patient, or his/her legal guardian, do hereby authorize the
(Print) (Last Name) (First Name) (Middle Initial) (circle one)
release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed______________________________ Date: *(mo)*________ *(day)*________ *(yr)*________

Return this form to: Allied National, Inc.
Attn: Claim Review
PO Box 29186
Shawnee Mission, KS 66201-9186
1-800-825-7531 or (fax number) 1-913-945-4399

If you have any questions concerning the independent review process, please feel free to call the Texas Department of Insurance at 1-888-TDI-2IRO (1-888-834-2476) for information.

REQUEST FROM A UTILIZATION REVIEW AGENT FOR ASSIGNMENT OF AN INDEPENDENT REVIEW ORGANIZATION

Today's date: Month_______________ Day_______________ Year_______________

Date request for Independent Review received by the Utilization review agent:
Month_______________ Day_______________ Year_______________

Reason For Request For Review By An Independent Review Organization: *(Check only one)*

☐ Appeal of Utilization Review Agent's Decision to Uphold, on Appeal, the Initial Adverse Determination

☐ Appeal of Determination Regarding a Life Threatening Condition

☐ Court Ordered review

FEIN *(Federal Tax ID Number)* of the Patient's Health Plan:____

Utilization Review Agent

FEIN number:______________________________ Certificate of Registration number:____________________

Name, address, phone number and fax number of Requesting Utilization Review Agent:

Name:____

Street:____

City:______________________________ State:_________________________ Zip Code:_______________

Phone number: _________-_________________ Fax number: _________-__________________ (if applicable)
(area code) *(number)* *(area code)* *(number)*

Name of person within the Utilization Review Agent organization who is the Independent Review Organization contact on this case (<u>very important</u>)

Name:____

Phone number: _________-________________ Fax number: _________-________________ (if different from above)
(area code) *(number)* *(area code)* *(number)*

Is the Utilization Review Agent also licensed as a Independent Review Organization? ☐ Yes ☐ No

If yes, provide the Independent Review Organization's Certificate of Registration number:_________________________

Patient's Provider of Record

Name, mailing address, phone number, fax number, and license, registration or certification number of patients provider of record: *(see definition)*

Federal Tax Identification Number:______________________________

Name:__________________________________ License Number:____

Street:____

City:______________________________ State:_________________________ Zip Code:_______________

Phone number: _________-_________________ Fax number: _________-__________________ (if applicable)
(area code) *(number)* *(area code)* *(number)*

PROVIDER OF RECORD - The physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the enrollee and includes any health care facility when treatment is rendered on an inpatient or outpatient basis.

Provide the name and license/certification/registration number of any physician or health care provider (physician/provider) who participated in the review/determination of the Utilization Review Agent.

1. ____

Name | Address | City | State | Zip Code

____

Phone Number | Fax Number | Federal Tax Identification Number | license/certification/registration number

2. ____

Name | Address | City | State | Zip Code

____

Phone Number | Fax Number | Federal Tax Identification Number | license/certification/registration number

3. ____

Name | Address | City | State | Zip Code

____

Phone Number | Fax Number | Federal Tax Identification Number | license/certification/registration number

4. ____

Name | Address | City | State | Zip Code

____

Phone Number | Fax Number | Federal Tax Identification Number | license/certification/registration number

5. ____

Name | Address | City | State | Zip Code

____

Phone Number | Fax Number | Federal Tax Identification Number | license/certification/registration number

If additional names need to be provided for the list of providers who participated in the utilization review decision to be complete use the attached page.

Was the initial review of the adverse determination performed by a physician who is a specialist? ☐ Yes ☐ No

If yes, provide the following information:

Name:______________________ License Number:______________________

State Licensed In:______________________ Review Specialty:______________________

Board Certified in Review Specialty ☐ Yes ☐ No

Was the appeal of the adverse determination reviewed by a physician who is a specialist? ☐ Yes ☐ No

If yes, provide the following information:

Name:______________________ License Number:______________________

State Licensed In:______________________ Review Specialty:______________________

Board Certified in Review Specialty ☐ Yes ☐ No

For each physician/provider known by the utilization review agent to have provided care to the patient and who may have records relevant to the review, provide the following information:

1. ____

Name | Address | City | State | Zip Code

____

Phone Number | Fax Number | Federal Tax Identification Number | license/certification/registration number

2. ____

Name | Address | City | State | Zip Code

____

Phone Number | Fax Number | Federal Tax Identification Number | license/certification/registration number

3.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	
4.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	
5.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	
6.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	
7.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	
8.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	
9.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	
10.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	
11.	Name	Address	City	State	Zip Code
	Phone Number	Fax Number	Federal Tax Identification Number	license/certification/registration number	

USE THE FOLLOWING PAGE ONLY if additional names need to be provided for the list of each physician/provider known by the utilization review agent to have provided care to the patient and who may have records relevant to the review or the list of physicians/providers who participated in the review/determination of the utilization review agent.

____. The reason for including the physician/provider on this list is: *(check one)*
1) Physician/Provider participated in the utilization review process ☐
2) Physician/Provider treated the patient and may have relevant records ☐

____.
Name Address City State Zip Code

Phone Number Fax Number Federal Tax Identification Number license/certification/registration number

____. The reason for including the physician/provider on this list is: *(check one)*
1) Physician/Provider participated in the utilization review process ☐
2) Physician/Provider treated the patient and may have relevant records ☐

____.
Name Address City State Zip Code

Phone Number Fax Number Federal Tax Identification Number license/certification/registration number

____. The reason for including the physician/provider on this list is: *(check one)*
1) Physician/Provider participated in the utilization review process ☐
2) Physician/Provider treated the patient and may have relevant records ☐

____.
Name Address City State Zip Code

Phone Number Fax Number Federal Tax Identification Number license/certification/registration number

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1) Physician/Provider participated in the utilization review process ☐
2) Physician/Provider treated the patient and may have relevant records ☐

____.
Name Address City State Zip Code

Phone Number Fax Number Federal Tax Identification Number license/certification/registration number

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1) Physician/Provider participated in the utilization review process ☐
2) Physician/Provider treated the patient and may have relevant records ☐

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Name Address City State Zip Code

Phone Number Fax Number Federal Tax Identification Number license/certification/registration number

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1) Physician/Provider participated in the utilization review process ☐
2) Physician/Provider treated the patient and may have relevant records ☐

____.
Name Address City State Zip Code

Phone Number Fax Number Federal Tax Identification Number license/certification/registration number

____. The reason for including the physician/provider on this list is: *(check one)*
1) Physician/Provider participated in the utilization review process ☐
2) Physician/Provider treated the patient and may have relevant records ☐

____.
Name Address City State Zip Code

Phone Number Fax Number Federal Tax Identification Number license/certification/registration number

____. The reason for including the physician/provider on this list is: *(check one)*
1) Physician/Provider participated in the utilization review process ☐
2) Physician/Provider treated the patient and may have relevant records ☐

____.
Name Address City State Zip Code

Phone Number Fax Number Federal Tax Identification Number license/certification/registration number