State Corporation Commission
Bureau of Insurance – External Review
P.O. Box 1157
Richmond, VA 23218
Phone: 1-877-310-6560 Fax: (804) 371-9915
Email: externalreview@scc.virginia.gov

EXTERNAL REVIEW REQUEST FORM

This External Review Request Form must be filed with the Virginia Bureau of Insurance within **120 DAYS** after receipt from your health carrier of a denial of payment on a claim or request for coverage of a health care service or treatment.

Name of Applicant: _____

Applicant is: (check one) ☐ Covered person/Patient ☐ Provider ☐ Authorized Representative
(**NOTE**: Form 216-B must be completed if the applicant is not the covered person.)

Covered Person Information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Phone: Home (_____) _____ Work (_____) _____

Fax: (_____) _____ Email: _____

Insurance Information:

Health Carrier Name: _____

Covered Person Insurance ID#: _____

Insurance Claim/Reference #: _____

Health Carrier Mailing Address: _____

_____

_____

Health Carrier Phone: _____

Employer Information:

Employer's Name: _____

Employer's Phone:(_____) _____

Is the health coverage you have through your employer a self-funded plan?_____.
(If you are not certain please check with your Human Resource office or plan administrator.)

Health Care Provider Information:

Treating Health Care Provider (for the denied services): _____

Address:

_____

_____

_____

Contact Person: _____ Phone: ( ) _____

Reason for Health Carrier Denial (Please check one):

☐ The health care service or treatment does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.

☐ The health care service or treatment is experimental or investigational (Form 216-D is required).

(**NOTE**: Other reasons for denial are not eligible for external review.)

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the health care service or treatment that was denied, and **attach a copy of the denial letter from your health carrier**).

_____
_____
_____
_____

Do not attach medical records at this time. If your appeal is determined to be eligible, you will be notified when and where to submit your medical records and other documentation in support of your appeal.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external review be handled on an expedited basis. You may not request an expedited review if the service has already been provided.
Has the service been provided? Yes_____ No _____

To complete this request, your treating health care provider **must** complete Form 216-C stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.*

Is this a request for an expedited review? Yes_____ No_____

*If you have received a final adverse determination involving emergency services, and you have not yet been discharged from a facility, check here____. Form 216-C is not required.

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I,_____, hereby request an external review. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize the health carrier, any third-party administrator, and the health care providers to release all relevant medical or treatment records to the independent review organization. I understand that the independent review organization will use this information to make a determination on this external review and that the information will be kept confidential and not be released to anyone else. This release is valid until the external review is complete.

_____ _____
Signature of Covered Person (or legal representative*) Date

_____
*Parent, Guardian, Conservator or Other – please specify

Form 216-B
(7/11)

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APPOINTMENT OF AUTHORIZED REPRESENTATIVE

- Complete this section only if someone other than the covered person is appealing.
- The covered person may represent himself, or may ask another person, including the treating health care provider, to act as the authorized representative.
- This authorization may be revoked at any time.

I hereby authorize _____to pursue an external review on my behalf.

_____ _____
Signature of Covered Person (or legal representative*) Date

_____
* Parent, Guardian, Conservator, or Other- please specify

Address of Authorized Representative:

_____

_____

_____

Phone: ( ) _____ Fax: ( ) _____ Email: _____

Form 216-C
(7/11)

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PHYSICIAN CERTIFICATION
EXPEDITED EXTERNAL REVIEW REQUEST
(To Be Completed by Treating Physician)

NOTE TO THE TREATING HEALTH CARE PROVIDER:

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.

The Commonwealth of Virginia State Corporation Commission Bureau of Insurance oversees external reviews. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION:

Name of Treating Health Care Provider: _____

Mailing Address: _____

Phone Number: (_____) _____Fax Number: (_____) _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

Patient's Health Carrier and Member ID#:_____

CERTIFICATION: I hereby certify that: I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard external review of the patient's appeal 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 that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____ _____

Signature Date

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PHYSICIAN CERTIFICATION
EXPERIMENTAL or INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for_____(patient's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health carrier's determination that the proposed therapy is experimental or investigational. I understand that in order for the patient to obtain the right to an external review of this denial, as treating physician I must certify that the patient's medical condition meets certain requirements:

In my medical opinion as the Patient's treating physician, I hereby certify to the following:
(Please check all that apply. NOTE: Requirements 1 - 3 are necessary to qualify for external review; requirements 1 – 4 are necessary to qualify for expedited external review.**)**

☐ 1. I am a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the patient's condition.

2. The patient has a condition that qualifies under one or more of the following:
(Please indicate which description(s) apply):
   - ☐ Standard health care services or treatments have not been effective in improving the patient's condition;
   - ☐ Standard health care services or treatments are not medically appropriate for the patient; or
   - ☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

3.
   - ☐ The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the patient than any available standard health care services or treatments; OR
   - ☐ It is my medical opinion which is based on scientifically valid studies using accepted protocols, that the health care service or treatment requested by the patient and which has been denied is likely to be more beneficial to the patient than any available standard health care services or treatments.

☐ 4. The health care service or treatment recommended would be significantly less effective if not promptly initiated (required for expedited external review only).

Please provide a description below of the recommended or requested health care service or treatment that is the subject of the denial. (Please attach additional sheets as necessary.)

Treating Physician's Name (please print): _____

_____ _____
Physician's Signature Date

Description of the health care service or treatment that is the subject of the denial:

Physician's signature

Date