1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free: 855.408.1212
Fax: 919.807.6865

External Review Request Form

Today's Date: _____

How did you hear about us? ☐ Friend ☐ Television ☐ Outreach Program ☐ Newspaper ☐ Insurer ☐ Family Member ☐ Brochure ☐ Physician Provider

Information on Covered Person (Person who was Denied the Services)

Name: _____

Address: _____
_____

Telephone: (H) _____ (W) _____
(Cell) _____ (Fax) _____

Email Address: _____

Date of Birth: _____ County: _____

Information on the Person Who is Authorized to Manage This Request for Covered Person

Name: _____

Address: _____

_____

Telephone: (H) _____ (W) _____
(Cell) _____ (Fax) _____

Email Address: ____ _____

Relationship to Covered Person (Person Denied Health Services): _____

☐ **By checking this box, I the covered person, attest that I have obtained permission from this person to handle this external review on my behalf.**

****IF YOU ARE A LEGAL GUARDIAN, POWER OF ATTORNEY OR EXECUTOR, PLEASE ATTACH/SUBMIT THE APPROPRIATE DOCUMENTS TO REFLECT YOUR AUTHORITY TO REQUEST THIS REVIEW.**

Information about doctor or provider who is performing or recommending the service

Name: _____
Practice: _____
Address: _____
Telephone: _____ Ext. _____ Fax: _____

About the Service that was Denied

The service that was denied is: _____

The service in question has already been provided: ☐ Yes ☐ No
I have completed all levels of appeal offered by my insurer: ☐ Yes ☐ No

Insurance Information

Insurance Company Name as it Appears on Card: _____
Name of Policy Holder: _____
Member ID: _____
Group Number: _____
Name of Treating Physician: _____
Name of Practice: _____
Address: _____
Phone Number: _____
Fax Number: _____
Name of Your Employer: _____
Spouse's Employer: _____
Spouse's Insurer: _____

About the External Review I am Requesting:

_____ I am requesting a standard external review, OR

_____ I am requesting an expedited external review. I understand I cannot make this request if the service has already been provided. I also further understand that a licensed medical professional will review this request to determine if the medical circumstances warrant an expedited handling of my request. Supplying information (medical records or supporting information) from my treating physician as to why this request should be handled expeditiously will help with the eligibility determination.

Check list

____ I have enclosed/attached a copy of my insurance card.

MEDICAL AUTHORIZATION RELEASE

The undersigned individual has requested an External Review pursuant to Part 4 of Article 50 of Chapter 58 of the NC General Statutes. In order to perform that review, the undersigned authorizes the North Carolina Department of Insurance ("NCDOI") to obtain from the Health Plan, whose decision is the subject of this request, and their sub-contractors, all information relating to the decision which is being reviewed including, but not limited to, his/her files and medical record information, which may include mental health information. Payment of fees for obtaining these records is the responsibility of the undersigned. The Covered Person also authorizes the NCDOI to provide, or to instruct the Health Plan and/or its sub-contractors to provide, such information to the Independent Review Organization ("IRO") assigned by NCDOI to perform the External Review.

The undersigned also acknowledges the following:

- Consent to the use of a translation service, at the expense of Smart NC, which shall treat the provided information as confidential, to translate any contents of this document that are submitted in a language other than English.
- NCDOI and/or the IRO may not be subject to the federal regulation pertaining to confidentiality and disclosure of medical records known as HIPAA. Despite the fact that HIPPA does not preclude NCDOI from re-disclosing medical record information, NCDOI and its agents are prohibited by North Carolina State law, specifically NCGS 58-2-105, from doing so for any purpose other than the review.
- He/she may revoke this authorization at any time. Your revocation will be effective upon receipt, but will not affect actions already taken on the basis of this Authorization. In any event, this authorization will automatically expire upon NCDOI and/or the IRO rendering a final decision regarding this External Review.

Print Name: _____

Signature: _____

DATE: _____

ACKNOWLEDGMENT OF RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS

This area must be signed by the covered person/patient only when the records relating to the denied service contain information relating to drug or alcohol abuse. This should be signed in addition to the Medical Authorization Release.

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by federal and/or state laws applicable to substance abuse. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information.

Signature of Covered Person if Applicable: _____

Date: _____