Aging and Disability Services Division

Office for Consumer Health Assistance

External Review Request Form

Submit this form to the Office for Consumer Health Assistance within **FOUR (4) MONTHS** of receiving denial notice of payment or coverage from your health plan.

Primary Insured's Name (First and Last): Applicant's Name (First and Last):
Applicant is the: ☐ Patient ☐ Provider ☐ Other

Covered Person/Patient Information	
Name (First and Last):	
Street Address:	
Cell Phone Number:	Work Phone Number:
Email Address:	

Insurance Information	
Name of Health Plan:	
Insurance Claim/Reference Number:	Insurance ID Number:
Health Plan Mailing Address:	
Health Plan Phone Number:	

Employer Information	
Employer Name:	Employer Phone Number:

Is your health coverage self-funded by your employer? ☐ Yes ☐ No

If unsure, ask your employer. Some self-funded plans have different ways to review information.

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Name of Provider:	Contact Person:
Address:	
Phone Number:	Email Address:
Medical Record Number:	

☐	The health care service or treatment is not medically necessary.
☐	The health care service or treatment is experimental or investigational.

Enter brief details of the claim and the denied health care service or treatment and attach a copy of the denial from your health plan. On page 4 of this document, you may explain in your own words the treatment that was denied and why you are asking for a review. You may also add extra pages to your request.

EXPEDITED REVIEW

If you need an expedited review, you can ask for it. Your doctor must fill out part of the form stating that waiting for treatment could harm the patient's health or recovery. Attach the form to your review request.

Are you asking for an expedited review? ☐ Yes ☐ No

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To ask for a review of your health plan's decision, sign and date this form and agree to release your medical records.

I, _____ request an external review. I agree that the information in this application is correct. I allow my insurance company and health care provider(s) to share my medical records with the independent review organization and the Office for Consumer Health Assistance. The medical records will be used for my external review and kept private. This approval ends when the case is closed.

_____ _____
Signature of Covered Person or Legal Representative Date

_____
Relationship to Recipient (i.e. Self, Parent, Guardian)

Health Care Service or Treatment Decision in Dispute In the section below please explain the service(s) not covered with the date(s) and why you do not agree. Add any extra pages, medical records, information from your health plan, studies, or notes from your doctor that may help.

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Items to add to the Request for External Review:

- Signed and dated application form.
- A copy of your insurance card or other proof of insurance.
- Letter from your health plan or utilization review company that states either:
  - ✓ Decision is final and internal review procedures are complete.
  - ✓ The requirement to complete the internal review is waived.

You can ask for an external review without going through all the internal review steps in some cases. Contact the number or address below for more help.

You can reach out to the Office for Consumer Health Assistance if you need help with the application or if you are missing any needed items and/or need other ways to complete your request. For standard external reviews or if you have more questions, please send all paperwork to:

Office for Consumer Health Assistance

7150 Pollock Drive

Las Vegas, NV 89119

Phone: (702) 486-3587 or (888) 333-1597

Fax: (702) 486-3586

Clear Form