STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Consumer Health Assistance
Bureau for Hospital Patients
7150 Pollock Drive | Las Vegas, Nevada 89119
Phone: (702) 486-3587 | Toll Free (888) 333-1597
Fax: (702) 486-3586 | E-mail: cha@govcha.nv.gov

EXTERNAL REVIEW REQUEST FORM

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Office for Consumer Health Assistance (OCHA) within **FOUR (4) MONTHS** after receiving a notice from your health plan of a denial of payment or request for coverage of a health care service or treatment.

Primary Insured's Name:
Applicant Name (☐ patient, ☐ provider, or ☐ authorized representative):

COVERED PERSON/PATIENT INFORMATION

First Name:	Last Name:		
Street Number and Name:	City:	State:	Zip Code:
Home Phone	Cell Phone	Work Phone	
Email Address:			

INSURANCE INFORMATION

Name of Health Plan:
Covered Person Insurance ID Number:
Insurance Claim/Reference Number:
Health Plan Mailing Address:
Health Plan Telephone Number:

EMPLOYER INFORMATION

Employer Name:
Employer Phone Number:

Is the health coverage you have through your employer a self funded plan? If you are not certain please check with your employer. Some self-funded plans may voluntarily provide external review, but may have different procedures.

HEALTH CARE PROVIDER INFORMATION

Name of Treating Physician/Health Care Provider:	
Address:	
Contact Person:	
Provider Phone Number:	Provider Email Address:
Medical Record Number:	

REASON FOR HEALTH PLAN DENIAL (Please check one)

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

SUMMARY OF EXTERNAL REVIEW REQUEST Enter a brief description of the claim, the request for health care service or treatment that was denied, and attach a copy of the denial from your health plan. *

*You may also describe in your own words the health care service or treatment in dispute and why you are requesting a review of this adverse determination using page 4 of this document or attach additional pages to your request.

EXPEDITED REVIEW

If you need a fast decision (expedited review), you may request your external review be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form 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. Attach the form to your external review request.

Is this a request for an expedited review? ☐ Yes ☐ No

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To request a review of your health plan's adverse determination, 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 my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Office for Consumer Health Assistance. I understand that the independent review organization and the Office for Consumer Health Assistance will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This authorization expires upon closure of OCHA case.

_____

Signature of Covered Person or Legal Representative* Date

_____

* Parent, Guardian, Conservator or Other (Please Specify) Date

Attach documentation of legal representation - Required upon submission

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this external review.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my external review on my behalf.

Print First and Last Name

Signature of Covered Person (or legal representative) * _____

*Parent, Guardian, or Other (please specify)_____

Address of Authorized Representative:		
Street Name and Number		
City:	State:	Zip Code:
Daytime Phone Number:	Evening Phone Number:	

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the disagreement with your health plan. Indicate clearly the service(s) being denied and the specific date(s) being denied. Explain why you disagree. Attach additional pages if necessary and include available medical records, any information you received from your health plan concerning the denial, any peer literature or clinical studies, and any additional information from your physician/health care provider that you want the independent review organization reviewer to consider.

Items to Include with Request for External Review:

☐ **YES**, I have included this completed application form signed and dated;

☐ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;

☐ **YES****, I have enclosed the letter from my health plan or utilization review company that states:

(a) ☐ Their decision is final and that I have exhausted all internal review procedures; or

(b) ☐ They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. Please contact the telephone number and or address listed below for further assistance.

You can call the Office for Consumer Health Assistance if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review and/or have additional 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

Certification of Treating Health Care Provider
For Expedited Consideration of a Patient's External Review

Note to the Treating Health Care Provider:

Patients can request an external review when a health plan 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 Office for Consumer Health Assistance assigns external review organizations. The standard external review process can take up to 45 days from the date the patient's request for external review is received by OCHA. Expedited external review is available only if the patient's treating health care provider certified that adherence to the time frame for the standard external review would jeopardize the covered person's ability to regain maximum function. OCHA will approve or deny a request for an external review in an expedited manner not later than 72 hours after receipt of proof from the provider of health care regarding the adverse determination concerns. This form is for the purpose of providing the certification necessary for OCHA to assign an independent review organization.

Name of Treating Physician/Health Care Provider:	
Address:	
Provider Phone Number:	Provider Fax Number:
Licensure and Area of Clinical Specialty:	

Name of Patient:
Patient's Insurer Member ID Number:

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; for this reason, the patient's request for an external review of the adverse determination by the patient's health plan of the requested health care service or course of the treatment should be processed on an expedited basis.

Treating Health Care Provider's Name: _____
(Please Print)

Signature: _____ Date _____

Physician Certification
Experimental/Investigational Denials
(To Be Completed by Treating Physician)

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

In my medical opinion as the Insured's treating physician, I hereby certify to the following: (Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

☐ 1. The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

☐ 2. The covered person has a condition that qualifies under one or more of the following: [please indicate which description(s) apply]:

- ☐ a. Standard health care services or treatments have not been effective in improving the covered person's condition;
- ☐ b. Standard health care services or treatments are not medically appropriate for the covered person; or
- ☐ c. There is no available standard health care service or treatment covered by the health plan 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 covered person 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.
Explain:

☐ 5. It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.
Explain:

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

Physician's Signature Date