MAXIMUS Federal Services

HHS-Administered Federal External Review Request Form

MAXIMUS Federal Services needs the information on this form to review your medical claim. We may not be able to do the review without this information.

In most cases, you must complete any mandatory appeals or opportunities for reconsideration offered by your health plan or insurance issuer before we can do an external review. In urgent situations, we may be able to do a review even if you have not made all appeals and reconsiderations.

We must receive the completed form within four months of the date your insurer sent you a final decision denying your services or your claim for payment.

Please read and complete all sections of this form.

Section 1: Covered person

This section is about the person who received or will receive the benefit or treatment.

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Please complete this section if you are the covered person's parent or legal guardian

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Questions? Call **1-888-866-6205** Monday – Friday 8:00am – 5:00pm EST

Section 2: Insurance company information

Please complete this section for each insurance company involved with your claim.

Insurance company #1:	Insurance plan or plan option (if applicable):
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Insurance company #2:	Insurance plan or plan option (if applicable):
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Section 3: Services in dispute

Please describe the health services that were denied by your health insurance plan or issuer:

Have you already received these health services? ☐ Yes ☐ No

If so, when were the services received? *(Month, day, year)* _____

Please state the reason that you believe the health insurance company's decision was not correct:

Questions? Call **1-888-866-6205** Monday – Friday 8:00am – 5:00pm EST

Section 4: Claims for urgent care situations

If you believe your situation is urgent, you may ask for an expedited (fast) review.

An urgent care situation is one in which your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision.

To ask for an expedited external review:

Fax this form to 1-888-866-6190 **OR** mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant's condition. The medical professional will not be required to submit proof of authorization.

If you have questions about your external review, call: **1-888-866-6205**.

Is this external review for urgent care? ☐ Yes ☐ No

Section 5: Claims involving a rescission of coverage

A **rescission** is an action by a health insurance issuer to retroactively cancel (back to an earlier date) or discontinue a policyholder's coverage.

Is this request for external review of a rescission of health insurance coverage? ☐ Yes ☐ No

Section 6: Additional information you may give

MAXIMUS Federal Services will use the information on this form to get the relevant information and documents from your insurer. You may add supporting information and documents you think the insurer may not be able to provide.

For example, you may choose to give us:

- Documents to support the claim, such as physicians' letters, reports, bills, medical records, and Explanation of Benefits (EOB) forms
- Letters you sent to your insurance plan or issuer about the claim
- Letters the plan or issuer sent to you about the claim

You do not have to give us this additional information. However, if you do not give us any additional information, MAXIMUS Federal Services may decide your case based only on the information your insurance issuer or plan gives us.

You can give MAXIMUS additional information for your external review by sending it with this form:

Fax to 1-888-866-6190 **OR** mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

If you have questions about your external review, call **1-888-866-6205**.

Questions?	Call **1-888-866-6205** Monday – Friday 8:00am – 5:00pm EST

Sign the consent form.

Please sign and date the form.

Signature: _____ Date: _____

Printed name: _____

I am the: ☐ Covered person ☐ Parent or legal guardian ☐ Authorized Representative

NOTE: The covered person must sign this consent form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form. If the covered person cannot sign this form, the authorized representative must give written proof of his or her authority to sign. You may write or call MAXIMUS in order to obtain a form to allow appointment of an Authorized Representative.

Privacy Act Statement: The following website provides a notice of your rights under the Privacy Act and includes information about how the information on this form will be used and about our legal authority to collect this information: **http://cciio.cms.gov/resources/other/index.html**.

MAXIMUS Federal Services

HHS Federal External Review Process Appointment of Representative Form

Please return this signed and completed form to the following address:
HHS Federal External Review Process
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Section 1: APPOINTMENT OF REPRESENTATIVE

NAME OF CLAIMANT	*PLAN|INSURANCE IDENTIFICATION NUMBER*

To be completed by the claimant:

I appoint this individual:_____ to act as my representative in connection with my request for external review by the HHS Federal External Review Process. I authorize this individual to make any request; to present or to produce evidence; to obtain external review information; and to receive any notice in connection with my external review, wholly in my place. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF CLAIMANT		*DATE*
STREET ADDRESS		*PHONE NUMBER*
CITY	*STATE*	*ZIP*

Section 2: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____ hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; and that I am not, as a current or former employee of the United States, disqualified from acting as the claimant's representative.

I am a / an _____
(Professional Status Or Relationship To The Claimant, E.G., Attorney, Relative, Etc.)

SIGNATURE OF REPRESENTATIVE		*DATE*
STREET ADDRESS		*PHONE NUMBER*
CITY	*STATE*	*ZIP*