Tennessee External Appeal Request for Authorization

Who is requesting external review?

- ❒ I am the member
- ❒ I am the member's Authorized Representative *(please complete the Appointment of Authorized Representative section)*

Member Info

Name:
OSC:
Date of Birth:
Mailing Address:
Daytime Phone:
Evening Phone:
Email:
Fax:
Case Number:

Authorized Representative Info

Name:
Mailing Address:
Daytime Phone:
Evening Phone:
Email:
Fax:

Treating Health Care Provider Info

Name:
Mailing Address:
Phone Number:
Email:
Fax:
Contact Person:
Phone Number:

External Review Details

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your case):

_____

_____

_____

_____

_____

_____

Appointment of Authorized Representative

You may 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.

_____ _____

Signature of Covered Person (or legal representative) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this appeal request form and consent to the release of medical records.

I _____ hereby request an external review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, health care provider and/or health plan issuer to release all relevant medical or treatment records to the independent review organization and/or the Tennessee Department of Insurance. I understand that this authorization permits Oscar to release copies of my identifiable medical records, x-rays or other required medical/dental information to the Independent Review Organization and/or the Tennessee Department of Insurance. This authorization includes but is not limited to a release of me medical/dental records, which may include records pertaining to the HIV/AIDS virus, or other sexually transmitted diseases, drug and/or alcohol testing or treatment, mental illness or psychiatric testing or treatment or genetic information, if applicable. I give my specific authorization for these confidential records to be released. I understand that the independent review organization and the Tennessee Department of Insurance 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 release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

_____ _____

Signature of Covered Person (or legal representative) Date

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

Please send this form and a copy of your adverse determination letters to:

Fax:	844-965-9054
Mail:	Oscar Insurance Attn: Tennessee Clinical Appeals PO Box 52146 Phoenix, AZ 85072

Be certain to keep copies of this form, your notice of final adverse determination, and all documents and correspondence related to this claim.

Can I provide additional information about my claim? Yes, as described in the Internal Appeals determination letter.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at the address noted on this form.