Ohio External Appeal Request for Authorization

Who is requesting external appeal?

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

How would you like us to contact you? ❒ Phone ❒ Fax ❒ Email ❒ Mail

Member Info

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

Authorized Representative Info

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 Appeal 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 appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representative) Date

External Appeal Details

1. If your situation is urgent, are you requesting an expedited review? YES NO

If you answer YES, your physician must complete the attached Physician Certification for Internal/External Appeals form.

2. Is your requested health care service considered an experimental or investigational treatment?

YES NO

If you answer YES, your physician must complete the attached Physician Certification for Experimental/Investigational Care form.

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 appeal. 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 Ohio Department of Insurance. I understand that the independent review organization and the Ohio Department of Insurance will use this information to make a determination on my external appeal 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 Buckeye State Insurance Corporation Attn: 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.

Physician Certification for Internal/External Appeals

Covered Persons may request an internal appeal and/or external appeal when a health plan issuer has denied a health care service or course of treatment. The standard internal appeal and external appeal processes can take up to 30 days from the request date to the date a decision is rendered. Expedited appeals or reviews are only available under the circumstances shown below. This form is for the purpose of providing the certification necessary to obtain an expedited appeal or review. Please complete any applicable sections and return the executed form to Oscar at the above fax or address.

Expedited Internal Appeal Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard internal appeal would, in my professional judgment, subject the covered person to severe pain that cannot be adequately managed without the requested care or treatment; and that, for this reason, the covered person's appeal should be processed on an expedited basis.

_____

Treating Physician Printed Name

_____ _____

Signature Date

Expedited Concurrent Appeal and External Appeal Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); and (select all that apply):

- ❒ That adherence to the time frame for conducting an expedited internal appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's expedited internal appeal should be conducted simultaneously with an expedited external appeal.

- ❒ That the recommended experimental or investigational treatment would, in my professional judgment, be significantly less effective if not promptly initiated; and that, for this reason, the covered person's expedited internal appeal should be conducted simultaneously with an expedited external appeal. I have attached the completed Physician Certification for Experimental/Investigational Care form.

_____

_____

_____

_____

_____

Treating Physician Printed Name

_____ _____

Signature Date

Expedited External Appeal Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard external appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's external appeal should be processed on an expedited basis.

_____

Treating Physician Printed Name

_____ _____

Signature Date

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Physician Certification for Experimental/Investigational Care

Covered Persons may request an external appeal when a health plan issuer has denied a health care service or course of treatment that is considered experimental or investigational and is NOT explicitly listed as an excluded benefit under the covered person's health benefit plan.

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health plan issuer'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 appeal 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 covered person's treating physician, I hereby certify to the following: (Please check all that apply)

- ❒ Standard health care services have not been effective in improving the condition of the covered person
- ❒ Standard health care services are not medically appropriate for the covered person
- ❒ There is no available standard health care service covered by the health plan issuer that is more beneficial than the requested health care service

Please provide a description of the recommended or requested health care service or treatment that is the subject of the adverse benefit determination. Please include any documentation that will be beneficial to the review process and attach additional notes as necessary.

_____

Treating Physician Printed Name

_____ _____

Signature Date