FIS 0018 (1/18) Department of Insurance and Financial Services

Health Care Appeals-Request for External Review You are eligible to request an External Review if ALL the following apply:

- You have exhausted the health carrier's internal grievance process (unless waived because the health carrier did not complete their review within the required time).
- . The request is within 127 days of receipt of a final adverse determination.
- . The patient was covered on the date of service.
- . The health care service appears to be a covered benefit.

The following types of policies are NOT eligible for review: Medicare supplement, disability income, hospital indemnity, specified accident, credit, long term care, and non-governmental self-funded plans.

You are responsible for submitting:

- · A copy of the final adverse determination from the health carrier
- Pertinent documentation, such as bills, explanations of benefits, medical records, correspondence, statements from doctors, research material that supports your position, etc.

Note: It is your responsibility to submit medical records. The Department of Insurance and Financial Services does not contact medical sources.

Always send copies. Never send original documents.

1. Patient Name							
		Name of INSURE) person	2.2	est is being file		
		102		The pa	itient-provide pat	tient's contact info	ormation in part 5
Name of Health Carrier (HMO, B	CBSM, Health Insu	irer)		The na	fiant's parent (if	nationt is a min	nor child); or the
							or legal guardian's
Policy number	Group numb	er (if applicable)	Claim number (if applicable		t information in pa	art 5	5115
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	10100000	79.00.000.000		represe	entative's contact		
Dates service was received or re	equested		e was received, enter date rece		nformation for p	erson filing this	form
Access to the second	0000	If not, er	ter date service was requested		ient, Parent, Legal	Guardian or Author	ized Representative
Physician and medical facility in	volved.						100
				Address			
2. Statement of request: P	rouide a brief exp	sanation of the pm	blem and the resolution you				
seeking. Describe the medic			orem and the resonator you				
				City		State	Zip
				Daytime phor	ne number	Evening ph	hone number
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				if you are not	the patient, what is	your relationship to	o the patient?
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TREATING PROVIDER CERTIFICATION FOR EXPERIMENTAL/INVESTIGATIONAL DENIALS (To be completed by the treating provider)

This form must be completed by the treating provider if your request for an external review involves a denial based on the health plan's determination that the service is experimental and/or investigational. Part 1 and Part 2 must both be completed in order for the Michigan Department of Insurance and Financial Services (DIFS) to accept the external review request. I hereby certify that I am the treating provider for (patient/covered person's name) and that I have requested the authorization for, or the patient/covered person has received, a drug, device, procedure, or therapy denied for coverage due to the health plan's determination that the service is experimental and/or investigational. I understand that in order for the patient/covered person to obtain the right to an external review of this denial, I must certify that the patient/covered person's medical condition meets certain requirements. 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.) **PLEASE INCLUDE RELATED MEDICAL RECORDS WITH THIS FORM.** In my medical opinion as the patient/covered person's treating provider, I hereby certify the following: PART 1 (REQUIRED) One or more of the following must apply (check all that apply): Standard health care services or treatments have not been effective in improving the covered person's condition; Standard health care services or treatments are not medically appropriate for the covered person; and/or 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. PART 2 (REQUIRED) One of the following must apply (check all that apply): The health care service or treatment I have recommended and which has been denied is, in my opinion, likely to be more beneficial to the patient/covered person than any available standard health care services or treatments. Scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the patient/covered person is likely to be more beneficial to the patient/covered person than any available standard health care services or treatments. Check only if you are a licensed, board-certified, or board-eligible provider qualified to practice in the area of medicine appropriate to treat the patient/covered person's condition. Treating Provider's Signature Date Print Name of Treating Provider Treating Provider's Address: Treating Provider's Phone Number: Fax Number

The completed form can be emailed to <u>difs-healthappeal@michigan.gov</u>, FAXED to 517-284-8838, or mailed to: DIFS – Office of General Counsel, Health Care Appeals Section, P.O. Box 30220, Lansing, MI 48909-7720

