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 INSURED person**

Name of Health Carrier (HMO, BCBSM, Health Insurer)

Policy number | **Group number** *(if applicable)* | **Claim number** *(if applicable)*

Dates service was received or requested ◀ *If service was received, enter date received. If not, enter date service was requested.*

Physician and medical facility involved.

2. Statement of request: Provide a brief explanation of the problem and the resolution you are seeking. Describe the medical services requested or received.*

***Form FIS 2326** (http://www.michigan.gov/documents/difs/FIS_2326_600931_7.pdf) **should be included with requests involving experimental or investigational denials. Please return the form completed and signed by your treating provider to DIFS within 30 days.**

3. EXPEDITED External Review Requirements *(if you are not requesting an expedited external review, or your request doesn't meet the conditions below, skip to Part 4)*

The following conditions must be met:

- An expedited INTERNAL review has been requested AND
- The request is filed within 10 days of receipt of adverse determination AND
- A physician substantiates the medical condition involved in the adverse determination is serious enough to jeopardize the life or health of the covered person.

My request meets these requirements. By completing items (3a.) and (3b.) below, I am requesting an Expedited External Review.

(3a.) Date you requested an expedited INTERNAL review _____

(3b.) Name and phone number of substantiating physician: _____

☐ I have included a letter from my physician.

4. This request is being filed by *(choose one)*

☐ **The patient**-*provide patient's contact information in part 5*

☐ **The patient's parent (if patient is a minor child); or the patient's legal guardian**-*provide parent or legal guardian's contact information in part 5*

☐ **A representative authorized by the patient**-*provide authorized representative's contact information in part 5.*

5. Contact information for person filing this form

Name of Patient, Parent, Legal Guardian or Authorized Representative

Address

City | **State** | **Zip**

Daytime phone number | **Evening phone number**

If you are not the patient, what is your relationship to the patient?

If person filing is NOT the patient or the patient's parent or the patient's legal guardian, the patient must designate the representative by reading and signing statement in part 6 below:

6. Patient authorization statement

I authorize the person named in Part 5 to act as my authorized representative in this External Review.

Signature of Patient | **Date**

7. Authorization to review medical information

I authorize the Department of Insurance and Financial Services (DIFS), the Independent Review Organization, the health carrier involved, and any other health care provider needed to review protected health information and records pertaining to this external review.

Signature of Patient | **Date**

8. Send your Request for External Review to

DIFS - Office of General Counsel - Appeals Section

(by mail)
P.O.Box 30220
Lansing, MI 48909-7720

(by courier/delivery)
530 W.Allegan Street, 7th Floor
Lansing, MI 48933

Fax: 517-284-8838

Phone: 877-999-6442

(by email) DIFS-HealthAppeal@michigan.gov

P.A. 251 of 2000 as amended, authorizes the Director to review requests for external review. Submission of this form is required to request an external review by the Director of the Department of Insurance and Financial Services.

FIS 2326 (09/17) Michigan Department of Insurance and Financial Services

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 | Print Name of Treating Provider | Date

Treating Provider's Address: _____

_____

Treating Provider's Phone Number: _____ Fax Number: _____

The completed form can be emailed to difs-healthappeal@michigan.gov, 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