

**Request for Independent External Review of an Adverse Benefit Determination**  
Applications for standard reviews can also be completed online at:  
[www.insurance.pa.gov/externalreview](http://www.insurance.pa.gov/externalreview)

**Member Information**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Member's Legal Guardian (if applicable): \_\_\_\_\_

Address of Member (or Legal Guardian): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

By selecting this box, I agree to receive electronic notices.

**Health Insurance Plan Information**

Name of Insurer: \_\_\_\_\_

Health Insurance Plan: \_\_\_\_\_

Insurer NAIC Number: \_\_\_\_\_

Subscriber or Member ID Number: \_\_\_\_\_

Insurance Claim/Reference Number: \_\_\_\_\_

**Health Care Decision in Dispute**

Date of Insurer Decision: \_\_\_\_\_

Service Denied: \_\_\_\_\_

Do you or your doctor think this was a medical emergency?  Yes  No

\*If yes, have your provider complete the physician certification and include with request

If any of your health care providers will be involved with this external review, please complete the following section:

Name of Health Care Provider: \_\_\_\_\_

Type of Provider:  Medical Doctor  Other (Please Specify): \_\_\_\_\_

Provider Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

**Describe your insurer's decision in your own words. Include whatever information you have about dates, names of health care providers, and details about the service(s) being denied. Explain why you disagree with the insurer. Attach additional pages if necessary.**

### **Member Representation**

#### **Fill Out This Section If Someone Will Be Representing You In This Appeal**

You can have a family member, friend, lawyer, or other person represent you or act on your behalf. You or your representative may ask your insurer to see any information your insurer has about the medical service(s) that is the subject of your external review.

Send member: Correspondence                      Send Representative: Correspondence  
Medical Records and Other    Medical Records and Other

I hereby authorize \_\_\_\_\_ to pursue this external review on my behalf and not (by this authorization) for any other purpose.

Representative's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Representatives Primary Phone Number: \_\_\_\_\_

Secondary Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

### Consent to Release and Exchange Information

I, \_\_\_\_\_, hereby request an external review of an adverse benefit determination and authorize the Pennsylvania Insurance Department to obtain copies of my medical records and all other information necessary for this review. The Department has my permission to release and exchange this information with my health insurer and an independent review organization certified by the Department, and with any health care provider or personal representative designated on this application form.

In addition, though I do not have a representative, I want the Department to be able to release and exchange all information related to this review with:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Member or Legal Guardian

\_\_\_\_\_  
Date

### Filing Instructions

**Applications for Standard Review may be completed online at:**

[www.insurance.pa.gov/externalreview](http://www.insurance.pa.gov/externalreview)

**Completed applications and any supporting information may be submitted by:**

**Faxing to: 717-231-7960**

**Emailing to: RA-IN-ExternalReview@pa.gov**

**Mailing to: Pennsylvania Insurance Department  
Attn: Bureau of Managed Care  
1311 Strawberry Square  
Harrisburg, PA 17120**