



## External Review Request Form

This form must be filed with Select Health within 180 DAYS for Self-Funded plans or within 4 MONTHS for Individual Colorado plans after receipt of an appeal denial. Requests for services that are excluded or benefit limitations are not eligible for external review.

Requestor's Name \_\_\_\_\_

Subscriber/Member    Provider    Authorized Representative

### MEMBER INFORMATION

Subscriber Name \_\_\_\_\_ Member Name \_\_\_\_\_

Address \_\_\_\_\_

Subscriber Ph#(\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Subscriber ID \_\_\_\_\_ Appeal Number: \_\_\_\_\_

### PROVIDER INFORMATION

Name of Servicing Provider/Facility \_\_\_\_\_

Address \_\_\_\_\_

Contact Person \_\_\_\_\_ Ph#(\_\_\_\_\_) \_\_\_\_\_

Medical Record Number (located on your provider's billing statement) \_\_\_\_\_

### EXPEDITED REVIEW

An expedited review is available if a delay would seriously jeopardize the life or health of the member or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited review?

Yes    No

If yes, your servicing provider must complete the Certification of Treating Healthcare Provider for Expedited Consideration of a Patient's External Review form.

### DENIAL REASON *(check one)*

- The service or treatment does not meet requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness.
- The service or treatment is experimental or investigational.

### EXPLANATION OF DISPUTE

Describe, in your own words, your disagreement with Select Health. Indicate clearly the service being denied and the specific date being denied. Attach additional pages if necessary, including available medical records, information you received from Select Health concerning the denial, related literature or clinical studies, and any additional information from your provider that you would like to be considered.

### EXPERIMENTAL OR INVESTIGATIONAL REVIEW

If the denial is based on a determination that the service or treatment is experimental or investigational, your servicing provider must complete the Physician Certification Experimental/Investigational Denials form.

**SIGNATURE AND RELEASE OF MEDICAL RECORDS**

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

I, \_\_\_\_\_, hereby request an external review. I attest that the information provided in this request form is true and accurate to the best of my knowledge. I authorize my healthcare providers to release all relevant medical or treatment records to the independent review organization and Select Health. I understand that the independent review organization and Select Health will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

\_\_\_\_\_  
**Signature of Subscriber/Member (or legal representative)**  
*Parent, Guardian, Conservator, or Other – Please Specify*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

**AUTHORIZED REPRESENTATIVE**

Complete this section only if someone else will be representing you in this appeal. You can represent yourself, or you may ask another person, including your provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize \_\_\_\_\_ to pursue my appeal on my behalf.

\_\_\_\_\_  
**Signature of Subscriber/Member (or legal representative)**  
*Parent, Guardian, Conservator, or Other – Please Specify*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

Address of Authorized Representative \_\_\_\_\_

Ph#(\_\_\_\_\_) \_\_\_\_\_

**COMPLETING YOUR REQUEST**

Your request for an external review will not be accepted unless you submit the following: This form completed, signed, and dated.

If an expedited external review is being requested, the completed Certification of Treating Healthcare Provider for Expedited Consideration of a Patient’s External Review form.

If the external review is being requested due to service or treatment that was determined to be experimental or investigational, the Physician Certification for Experimental/Investigational Denials form.

If you have questions, call Select Health Appeals at **844-208-9012** weekdays, from 8:00 a.m. to 5:00 p.m.

For a standard external review or one that involves experimental or investigational service or treatment, send all paperwork to the following:

**Select Health**  
**Attn: Appeals and Grievances Department**  
**P.O. Box 30192**  
**Salt Lake City, UT 84130-0192**

**Fax: 801-442-0762**  
**Email: [appeals@imail.org](mailto:appeals@imail.org)**

For Colorado plans: The Colorado Division of Insurance assigns the Independent Review Organization that will complete the review.



**Select  
Health**

P.O. Box 30192  
Salt Lake City, UT 84130-0192  
801-442-5038/800-538-5038  
selecthealth.org

## Certification of Treating Healthcare Provider for Expedited Consideration of a Patient's External Review

### NOTE TO THE TREATING HEALTHCARE PROVIDER

Patients can request an external review when Select Health has denied a service or treatment on the basis of a utilization review determination that the requested service or treatment does not meet requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment requested. The standard external review process can take up to 45 days from the date the member's request for external review is received. Expedited external review is available only if the member's treating healthcare provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the member or would jeopardize their ability to regain maximum function. An expedited external review must be completed within 72 hours. This form is for the purpose of providing the certification necessary to initiate an expedited review.

### GENERAL INFORMATION

Name of Servicing Provider \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Ph#(\_\_\_\_\_) \_\_\_\_\_ FAX(\_\_\_\_\_) \_\_\_\_\_  
Credentials \_\_\_\_\_  
Name of Patient \_\_\_\_\_ Subscriber ID \_\_\_\_\_

### CERTIFICATION

I hereby certify that I am the servicing provider for \_\_\_\_\_ (hereafter referred to as "the member"). I believe that adherence to the time frame for conducting a standard external review of the member's appeal would, in my professional judgment, seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, and that, for this reason, the member's appeal of the denial by Select Health of the requested service or treatment should be processed on an expedited basis.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_



Select Health

P.O. Box 30192  
Salt Lake City, UT 84130-0192  
801-442-5038/800-538-5038  
selecthealth.org

## Physician Certification for Experimental/Investigational Denials

To be completed by the servicing provider

I hereby certify that I am the servicing provider for \_\_\_\_\_ and that I have requested the authorization for a drug, device, procedure, or therapy denied for coverage due to a determination that the proposed therapy is experimental and/or investigational. I understand that in order for the member to obtain the right to an external review of this denial, as servicing provider I must certify that the member's medical condition meets certain requirements.

In my medical opinion as the member's servicing provider, I hereby certify to the following:

The insured has a condition that qualifies under one or more of the following:

**Check all that apply:**

- Standard healthcare services or treatments have not been effective in improving the member's condition;
- Standard healthcare services or treatments are not medically appropriate for the member; or
- There is no available standard healthcare service or treatment covered by the insurer that is more beneficial than the requested or recommended healthcare service or treatment.
- The healthcare service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the insured than any available standard healthcare services or treatments.
- The healthcare service or treatment recommended would be significantly less effective if not promptly initiated.

Explain

- It is my medical opinion, that based on scientifically valid studies using accepted protocols that the healthcare service or treatment requested by the member and which has been denied is likely to be more beneficial to the member than any available standard healthcare services or treatments.

Explain

Provide a description of the recommended or requested service or treatment that is the subject of the denial. Please attach copies of any supporting documents.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Fair Treatment Notice

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

We provide free:

- Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).
- Help for those whose first language is not English, such as interpreters or member materials in other languages.

Need help? Call Select Health Member Services at **800-538-5038**.

If you feel you've been treated unfairly, call Select Health 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

## Language Access Services

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Select Health

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해 주십시오.

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्नुहोस्।

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select Health.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

**ATTENTION:** si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez Select Health.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Select Health. まで、お電話にてご連絡ください。

ማሳሰቢያ: ከማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። Select Health ን ያናግሩ።

**ПАЖЊА:** Ако говорите Српски, бесплатне услуге помоћи за језик, биће вам доступне. Контактирајте Select Health.

تامدخ لكل رفوتت سف، یبرع ترحت تنك اذا یدی بنات  
Select Health. اب لصرتا. اناجم فیوغلل اذع اسملا

تامدخ، یدی نکی م تب حص ینی ن ک دراو ار نابز هب رگا : هجوت  
اب. ت سامش رای تخ ا رد ناگی ار تروص ب، ینی نابز کم ک  
یدی رگی ب سامت Select Health

หมายเหตุ: หากคุณพูด ใ้ภาษา, การบริการภาษา โดย  
ไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select  
Health

**Select Health: 1-800-538-5038**