Select Health

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

External Review Request Form

This form must be filed with Select Health if one of the following applies.

1. **Self-Funded Group Plans:** If an external review for medical necessity or experimental denial is received you must file the External Review Request form within **180 days** of receiving the appeal denial.
2. **Colorado Plans:** If an external review for medical necessity or experimental/investigational denial is received you must file the External Review Request form within **4 months** of receiving the appeal denial.
3. **Individual Qualified Health Plans (QHP) in Utah, Idaho, Nevada, and Colorado:** If a Non-Formulary drug exception request denial is received you must file the External Review Request form within **180 days** of receiving the appeal denial. This process applies for QHP coverage obtained through **HealthCare.gov** or a State-Based Marketplace, and for QHP coverage obtained directly from Select Health.

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.

❑ Non-formulary drug or step therapy exception.

❑ 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) **Date**

Parent, Guardian, Conservator, or Other—Please Specify

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) **Date**

Parent, Guardian, Conservator, or Other—Please Specify

Address of Authorized Representative _____

Ph# (_____) _____ Email: _____

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 and Grievances 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@selecthealth.org

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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** _____ / _____ / _____

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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

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.

주의: 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፡ አማርኛ 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.

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بـ Select Health.

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان سے متعلق مدد کی خدمات مفت میں دستیاب ہیں۔ Select Health پر کال کریں

ความสนใจ: หากคุณพูดภาษาไทย, การบริการทางภาษา โดยไม่เสียค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

Select Health: 1-800-538-5038