

Vermont Department of Banking, Insurance, Securities and Health Care Administration
**REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF A
HEALTH CARE DECISION**

PATIENT INFORMATION

Patient's Name: _____

Name of Patient's Legal Guardian (if applicable): _____

Address for Patient (or Legal Guardian): _____

***Please include Street Address _____

Phone Number: Daytime: _____ **Evening:** _____

**FILL OUT THIS SECTION ONLY IF SOMEBODY ELSE
WILL REPRESENT YOU IN THIS APPEAL**

You can represent yourself, or you may ask another person to make your appeal for you, acting as your personal representative. If you choose to do this, tell us who is representing you and sign the authorization for that person to act for you. NOTE: You may revoke this authorization at any time.

Please send **patient:** correspondence medical records & other attachments
Send **representative:** correspondence medical records & other attachments

I hereby authorize _____ to pursue this appeal on my behalf and not (by this
(Name of Personal Representative, if one used)
authorization) for any other purpose.

Signature of Patient (or Legal Guardian if applicable)

Date

Representative's Mailing Address (including Street Address):

Representative's Phone Number: Daytime: _____ **Evening:** _____

FILL OUT THIS SECTION IF YOU WANT TO HAVE A TELEPHONE CONFERENCE

If you think you (and, if you wish, your health care provider) might want to discuss your case with the independent review organization and your insurer in a telephone conference, please request it now.

- Yes, I want a phone conference. No, I do not want a phone conference. I understand this means the reviewer will base the decision on the written information only.

HEALTH INSURANCE PLAN INFORMATION

Name of Insurer: _____

Person at Health Insurance Plan involved with your appeal: _____

Insurer Mailing Address: _____

Insurer Area Code and Phone Number: _____

Subscriber or Member Number: _____ **Insurance Claim/Reference Number:** _____

SEE OTHER SIDE

HEALTH CARE DECISION IN DISPUTE

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 services being denied. Explain why you disagree with the insurer. Attach additional pages if necessary.

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

If any of your health care provider(s) will be involved with this appeal, please complete the next section:

Name of Health Care Provider: _____

Type of Provider: medical doctor other (please specify): _____

Provider Mailing Address: _____

Provider Phone Number: _____

CONSENT TO RELEASE AND EXCHANGE INFORMATION

I, _____, hereby request independent external review and authorize the Division of Health Care Administration to obtain copies of my medical records and all other information necessary for this review. The Division has my permission to release and exchange this information with my health insurer and an independent review organization on contract to the Division, and with any health care provider or personal representative designated on this application form.

I do not have a representative but I want the Division to be able to release and exchange all information related to this review with

_____.

Signature of Patient (or Legal Guardian if applicable)

Date

REQUEST TO REDUCE OR WAIVE FILING FEE

I have a financial hardship and cannot pay the \$25.00 filing fee:

- I am eligible for unemployment assistance, fuel assistance, food stamps, WIC, SSI, TANF, General Assistance, Medicaid or another state or federal assistance program.
- I am not eligible for state or federal assistance programs, but I have a financial hardship because:

WHAT TO SEND AND WHERE TO SEND IT

- This completed application form.** Call the Division at **800-631-7788** if you need help with this application.
- A copy of the letter from your health insurer,** denying your request at the final level of their appeals process.
- A check or money order** in the amount of \$25.00, payable to the **Division of Health Care Administration.** **Do not send a check or money order if you completed the above Request To Reduce Or Waive Filing Fee.**

Send all paperwork to: David Martini – External Appeals
Vermont Division of Health Care Administration (3rd Floor)
89 Main Street
Montpelier, VT 05620-3601

