STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001
Carson City, Nevada 89701
Telephone (775) 684-7000 · (800) 326-5496
Fax (775) 684-7028
www.pebp.state.nv.us

BRIAN SANDOVAL
Governor

DAMON HAYCOCK
Executive Officer

PATRICK CATES
Board Chairman

EXTERNAL REVIEW REQUEST FORM

1. This **EXTERNAL REVIEW REQUEST FORM** must be filed with Office for Consumer Health Assistance within **FOUR (4) MONTHS** after receipt from your insurer/HMO of a denial of payment on a claim or request for coverage of a health care service or treatment.

APPLICANT NAME _____
Covered person/Patient Provider Authorized Representative

COVERED PERSON/PATIENT INFORMATION
Covered Person Name: _____
Patient Name: _____
Address:
_____
_____

Covered Person Phone #: Home (_____) _____
Work (_____) _____

INSURANCE INFORMATION
Insurer Name: _____
Covered Person Insurance ID#:
_____
Insurance Claim/Reference #:
_____

Insurer Mailing Address:
_____
_____

Insurer Telephone #:
(_____)_____
EMPLOYER INFORMATION
Employer's Name:
_____
Employer's Phone #:
(_____)_____

HEALTH CARE PROVIDER INFORMATION
Treating Physician/Health Care Provider:

_____

Address:

_____

_____

_____

Contact Person: _____

Phone: ( ) _____

Medical Record #:_____

REASON FOR HEALTH CARRIER DENIAL (Please check one)

- ☐ The health care service or treatment is not medically necessary.
- ☐ The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

_____

_____

_____

_____

_____

_____

*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using page 4 of this document or attach additional pages to your request.

2. EXPEDITED REVIEW

If you need a fast decision (expedited review), you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out a certification of treating health care provider form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. This form should be attached to your external review request.

Is this a request for an expedited appeal? Yes _____ No _____

3. SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I

authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Office for Consumer Health

Assistance. I understand that the independent review organization and the Office for Consumer Health Assistance will use this information to make a determination on my external 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 Covered Person (or legal representative)* Date

_____

*(Parent, Guardian, Conservator or Other – Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out 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 treating health care 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 Covered Person (or legal representative)* Date
*(Parent, Guardian, Conservator or Other—Please Specify)
Address of Authorized Representative:

_____

_____

Phone #: Daytime (_____) _____
Evening (_____) _____

4. HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the disagreement with your Health carrier. Indicate clearly the service(s) being denied and the specific date(s) being denied. Explain why you disagree. Attach additional pages if necessary and include available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies, and any additional information from your physician/health care provider that you want the independent review organization reviewer to consider.

5. WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED).

- ☐ **YES**, I have included this completed application form signed and dated;
- ☐ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
- ☐ **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
  (a) Their decision is final and that I have exhausted all internal review procedures; or
  (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.
- ☐ **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. Please contact the telephone number and or address listed below for further assistance.

You can call the Office for Consumer Health Assistance if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review and/or have additional questions, please send all paperwork or address questions to:

Office for Consumer Health Assistance
555 East Washington #4800
Las Vegas NV 89101.
Phone: (702) 486-3587 or (888) 333-1597
Fax: (702) 486-3586
Web: www.govcha.nv.gov

NOTE: If you are requesting an expedited external review, please call the Office for Consumer Health Assistance at (702) 486-3587 or (888) 333-1597 before sending your

paperwork and you will receive instructions on the quickest way to submit the application and supporting information.