EXTERNAL REVIEW REQUEST FORM

Name of person filing request for external review ______________________________

Relationship to covered person ☐ Covered Person/Applicant

☐ Authorized Representative *(please complete the Appointment of Authorized Representative section)*

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Mailing Address	City	State	Zip code
Daytime Phone		Evening Phone	
Email Address		Fax	

COVERED PERSON/APPLICANT INFORMATION

Name		ID Number	
Mailing Address	City	State	Zip code
Daytime Phone		Evening Phone	
Email Address		Fax	

TREATING PHYSICIAN/HEALTHCARE PROVIDER INFORMATION

Name		Phone Number	
Mailing Address	City	State	Zip code
Email Address		Fax Number	
Contact Person		Phone Number	

External Review Specifications

1. If your situation is urgent, are you requesting an expedited review?* ☐ Yes ☐ No

   *If you answer yes, your physician must certify your condition could, in the absence of immediate medical treatment, result in the following:

   - Seriously jeopardize your life or health or your ability to regain maximum function, or
   - Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Is your requested healthcare service considered an experimental or investigational treatment?** ☐ Yes ☐ No

**If you answer yes, your physician must certify that they are requesting authorization for a drug, device, procedure, or therapy denied for coverage due to the determination that the treatment is experimental and/or investigational and your medical condition meets certain requirements:

- Standard healthcare services have not been effective in improving your condition.
- Standard healthcare services are not medically appropriate for you.
- There is no available standard healthcare service covered by the health plan issuer that is more beneficial than the requested healthcare service.

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

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Appointment of Authorized Representative (complete when someone else is representing you in this appeal)
You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.
I hereby authorize to pursue my external review on my behalf.

______________________________________ ______________________

Signature of Covered Person (or legal representative*) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I hereby request an external review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider and/or health plan issuer to release all relevant medical or treatment records to the Independent Review Organization and/or the Ohio Department of Insurance. I understand that the Independent Review Organization and the Ohio Department of Insurance will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

______________________________________ ______________________

Signature of Covered Person (or legal representative*) Date

**Parent, Guardian, Conservator or Other - please specify*

Send this form and a copy of your notice of final adverse benefit determination to one of the following:

Mailing Address:
Grievance and Appeal Coordinator
P.O. Box 6029 Canton, OH 44706

Fax Number: 330-363-3066

Email Address: Aappeals@aultcare.com

Be certain to keep copies of this form, your Notice of Final Adverse Benefit Determination, and all documents and correspondence related to this claim.