Health Care Appeals-Request for External Review

You are eligible to request an External Review if ALL the following apply:

- You have exhausted the health carrier's internal grievance process (unless waived because the health carrier did not complete their review within the required time).
- The request is within 127 days of receipt of a final adverse determination.
- The patient was covered on the date of service.
- The health care service appears to be a covered benefit.

The following types of policies are NOT eligible for review: Medicare supplement, disability income, hospital indemnity, specified accident, credit, long term care, and non-governmental self-funded plans.

You are responsible for submitting:

- A copy of the final adverse determination from the health carrier
- Pertinent documentation, such as bills, explanations of benefits, medical records, correspondence, statements from doctors, research material that supports your position, etc.

Note: It is your responsibility to submit medical records. The Department of Insurance and Financial Services does not contact medical sources.

Always send copies. Never send original documents.

1. Patient Name | Name of INSURED person

Name of Health Carrier (HMO, BCBSM, Health Insurer)

Policy number | Group number *(if applicable)* | Claim number *(if applicable)*

Dates service was received or requested ◀ *If service was received, enter date received. If not, enter date service was requested.*

Physician and medical facility involved.

2. Contact information for patient for whom the request is being made

Name of Patient, Patient's Parent, or Legal Guardian (if a minor)

Address

City | State | Zip

Daytime phone number | Evening phone number

Email Address

3. **EXPEDITED External Review Requirements** *(if you are not requesting an expedited external review, or your request doesn't meet the conditions below, skip to Part 4)*

The following conditions must be met:

- An expedited INTERNAL review has been requested AND
- The request is filed within 10 days of receipt of adverse determination AND
- A physician substantiates the medical condition involved in the adverse determination is serious enough to jeopardize the life or health of the covered person.

My request meets these requirements. By completing items (3a.) and (3b.) below, I am requesting an Expedited External Review.

(3a.) Date you requested an expedited INTERNAL review _____

(3b.) Name and phone number of substantiating physician: _____

☐ I have included a letter from my physician.

4. This request is being filed by *(choose one)*

☐ **The patient**-*provide patient's contact information in part 2*

☐ **The patient's parent (if patient is a minor child); or the patient's legal guardian**-*provide parent or legal guardian's contact information in part 2*

☐ **A representative authorized by the patient**-*provide authorized representative's contact information in part 5 and the patient's contact information in part 2.*

5. Contact information for person filing this form

Name of Authorized Representative

Address

City | State | Zip

Daytime phone number | Evening phone number

Email Address

If you are not the patient, what is your relationship to the patient?

If person filing is NOT the patient or the patient's parent or the patient's legal guardian, the patient must designate the representative by reading and signing statement in part 6 below:

6. Patient authorization statement

I authorize the person named in Part 5 to act as my authorized representative in this External Review.

Signature of Patient, Parent if a minor, or Legal Guardian | Date

7. Authorization to review medical information

I authorize the Department of Insurance and Financial Services (DIFS), the Independent Review Organization, the health carrier involved, and any other health care provider needed to review protected health information and records pertaining to this external review.

Signature of Patient, Parent if a minor, or Legal Guardian | Date

8. Send your Request for External Review to: DIFS - Office of Appeals and Market Regulation - Appeals Section

(by mail)
P.O.Box 30220
Lansing, MI 48909-7720
Fax: 517-284-8838

(by courier/delivery)
530 W. Allegan Street, 7th Floor
Lansing, MI 48933
Phone: 877-999-6442

(by email) DIFS-HealthAppeal@michigan.gov

*****Please use the second page to describe your complaint and desired outcome.*****

P.A. 251 of 2000 as amended, authorizes the Director to review requests for external review. Submission of this form is required to request an external review by the Director of the Department of Insurance and Financial Services.

9. Statement of request: Provide a brief explanation of the problem and the resolution you are seeking. Describe the medical services requested or received.* (Include related denial letters, explaination of benefits, bills, etc.) You may attach additional pages if there is not enough room available here to explain your problem.

***Form FIS 2326** (https://www.michigan.gov/-/media/Project/Websites/difs/Form/Complaint/FIS_2326.pdf) **should be included with requests involving experimental or investigational denials. If form FIS 2326 is not included with your request for external review, please return form FIS 2326 which has been completed and signed by your treating provider to DIFS within 30 days, or your request will be closed without a review.**