INDEPENDENT REVIEW REQUEST

Use this form to request an Independent Review of a Health Benefit Plan Adverse Benefit Determination, which is administered by the Utah Insurance Department (UID) in accordance with Utah Code § R590-261. Please follow the steps below to submit the form successfully to our office.

STEP 1: ***Review the Independent Review Request form and Additional Information.***

STEP 2: ***Complete the Independent Review Request Form***. Please submit one form for an Adverse Benefit Determination.

STEP 3: ***Enclose the supporting documentation***. Have you gathered all the necessary information to submit with your form? Any missing or incomplete information will delay the request.

Checklist:

Required Documents	***Supplemental Documents***
☐ Completed and signed form	☐ Expedited Request Certificate
☐ A copy of the insurance card	☐ Experimental/Investigational Certificate
☐ A copy of the denial letter	☐ Supporting medical records/documents

STEP 4: ***Fax, mail or email the completed form and documentation to UID.***

Fax:
UTAH INSURANCE DEPARTMENT
ATTN: HEALTH DIVISION (IRO)
(385) 465-6047

Electronic Mail (email):
healthappeals@utah.gov

Regular Mail:
UTAH INSURANCE DEPARTMENT
ATTN: HEALTH DIVISION (IRO)
4315 S 2700 WEST
TAYLORSVILLE UT 84129

Please keep a copy of the completed form and documentation for your records.

***Please Note**: you may request an independent review without exhausting all internal review procedures under certain circumstances. Call the UID Health Division at (801) 957-9280 for further information.*

TIME FRAME

Following the receipt of your properly completed form and documentation, we will contact you as soon as possible (typically within 1 business day). Please be sure your contact information is provided on the form.

The review process will vary on the type of request (typically 7 days for an expedited request; 55 days for a standard request).

INDEPENDENT REVIEW REQUEST

1 REQUESTOR INFORMATION

Requestor's Name:

Relationship to Insured/Patient:

Your Address:

Preferred method of communication? ◯ **Email** ◯ **Fax** ◯ **US Mail**

Phone: *Home Cellular Business*

Fax:

Email: (*Required*)

2 INSURED INFORMATION

Insured/Patient Name:

Insured/Patient Birth Date:

Insurance Carrier Name:

Insurance ID #

Type of insurance coverage?

◯ Individual ◯ Group

Employer Name: (*if Group Policy*)

State where purchased?

3 HEALTH CARE PROVIDER INFORMATION

Provider Name:

Medical Record #

Provider Address:

Phone:

Fax:

Email: (*Required*)

4 INDEPENDENT REVIEW INFORMATION

Reason for insurance carrier denial? ◯ **Medical Necessity** ◯ ***Experimental or Investigational*** ◯ **Rescinded Coverage**

Is this an expedited review? ◯ **Yes** ◯ **No**

Have an Experimental/Investigational Certificate completed by the treating physician.

RETURN TO UID https://insurance.utah.gov/consumer/health/independent-review

INDEPENDENT REVIEW REQUEST

Insured's Name: _____ **UID #** _____

5 HEALTH CARE SERVICE IN DISPUTE

Briefly describe the disagreement with the insurance carrier. Indicate clearly the service being denied and the specific date(s). Attach additional pages if necessary. Include pertinent medical records, information received from the carrier concerning the denial, literature or clinical studies, and information from the treating physician or provider.

☐ See the attached explanation letter.

6 AUTHORIZATION AND RELEASE OF MEDICAL RECORDS

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

I, _____ , hereby request and independent review.

- I attest that the information provided in this request form is true and accurate to the best of my knowledge.
- I authorize my carrier and my health care providers to release all relevant medical or treatment records, including any records pertaining to HIV/AIDS, mental health, and substance abuse, to the independent review organization and the Utah Insurance Department.
- I understand that the independent review organization and the Utah Insurance Department 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.
- I understand that I have the right to revoke this authorization in writing at any time except to the extent that action has already been taken based on this authorization.

* This release is valid for one year. *

Signature of Insured or legal representative

Date

7 APPOINTMENT TO DISCLOSE INFORMATION

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. This allows the individual listed below to act on the insured's behalf. You may revoke this authorization at any time.

I hereby authorize _____

to pursue my appeal on my behalf.

Signature of Insured or legal representative

Date

EXPERIMENTAL/INVESTIGATIONAL INDEPENDENT REVIEW
Certification by Treating Physician

Insured's Name: _____ **UID #** _____

I hereby certify that I am the treating physician for the above named insured, and I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the carrier's decision that the proposed therapy is experimental and/or investigational. I understand that in order for the insured to obtain the right to an independent review of this denial, as treating physician I must certify that the insured's medical condition meets certain requirements:

In my medical opinion as the insured's treating physician, I hereby certify to the following: (*Check all that apply*)

1. The insured has a condition that qualified under one or more of the following:
   - ☐ a. Standard health care services or treatments have not been effective in improving the insured's condition;
   - ☐ b. Standard health care services or treatments are not medically appropriate for the insured; or
   - ☐ c. There is no available standard health care or treatment covered by the insurer that is more beneficial than the requested or recommended health care service or treatment.

☐ 2. The health care 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 health care services or treatments.

☐ 3. The health care service or treatment recommended would be significantly less effective if not promptly initiated. *(Please explain below).*

☐ 4. It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the insured and which has been denied is likely to be more beneficial to the insured than any available standard health care services or treatments. *(Please explain below).*

Provide a description of the recommended or requested health care service or treatment that is the subject of the denial. *(Attach additional sheets as necessary)*

Provider Name:

Medical Record #

Provider Address:

Phone:

Fax:

Email: (*Required*)

Signature of treating physician

Date

RETURN TO UID (If applicable) https://insurance.utah.gov/consumer/health/independent-review

EXPEDITED INDEPENDENT REVIEW

Certification by Treating Health Care Provider

Insured's Name: _____ **UID #** _____

NOTE TO THE TREATING HEALTH CARE PROVIDER:

Patients can request an independent review when a carrier has denied a health care service or course of treatment on the basis of a determination that the requested health care service or course of treatment does not meet the carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Utah Insurance Department oversees requests for an independent review. The standard independent review process can take up to 45 days from the date the patient's request for independent review is received by our department. Expedited independent review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard independent review would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function. An expedited independent review must be completed within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

Provider Name:

Medical Record #

Provider Address:

Phone:

Fax:

Email: (*Required*)

CERTIFICATION:

I hereby certify that I am a treating health care provider for the above named insured and that adherence to the time frame for conducting a standard independent review of the insured's appeal would, in my professional judgment, seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; and that, for this reason, the insured's appeal of the denial by the insured's carrier of the requested health care service or treatment should be processed on an expedited basis.

Signature of treating physician

Date

RETURN TO UID (If applicable) https://insurance.utah.gov/consumer/health/independent-review

Frequently Asked Questions

What is an adverse benefit determination?
An adverse benefit determination is when a health insurance carrier denies, reduces, or terminates a benefit or rescinds health insurance coverage.

What rights do I have if an adverse benefit determination happens?
You may request an appeal or independent review.

How can I find out if I qualify for an appeal or independent review?
Your policy, certificate, or plan document will contain an explanation of the rights you have if an adverse benefit determination happens or you can ask your health insurance carrier.

When can I request an Independent Review?
Upon receiving notification of an adverse benefit determination, you must first request an internal appeal or review by the health insurance carrier. If the health insurance carrier upholds the initial decision, you may then submit a request for an independent review.

Who administers the Independent Review process?
The independent review process is administered by either the health insurance carrier or the Utah Insurance Department depending upon the type of health insurance. Contact your health insurance carrier to learn who administers the independent review process for your health insurance coverage.

Who reviews my Independent Review request?
A randomly selected independent review organization which is independent from your health care provider and insurance carrier.

What if the claim is for urgently needed care?
If the adverse benefit determination involves a medical condition that would jeopardize your life or health, an expedited review is available. Information in addition to the Independent Review Request form is required. The Certification of Treating Health Care Provider for Expedited Consideration of a Patient's Independent Review page of the request form must be completed.

Does the Utah Insurance Department regulate all health insurance coverage?
No. In fact, your coverage may be regulated by the Federal government. Contact your insurance carrier and ask before you start the review process.

What if the claim is for experimental or investigational treatment?
Information in addition to the Independent Review Request Form is required. The Physician Certification for Experimental/Investigational Denials page of the request form must be completed.

What is an internal appeal?
An internal appeal is an appeal with the your insurance carrier. Depending on the type of coverage, you may have more the one level of an internal appeal.

Is there another step after I complete an Independent Review?
No. The decision made during the review process is legal and binding. There is no other option the Department can provide after the decision is rendered.

How do I request an Independent Review?
Complete the Independent Review Request form located on our below web site listed below. If you do not have internet access or a printer, call (801) 538-3077 to have a form mailed to you.

What is the time limit to submit an independent review request to the Department?
You must submit your request within 180 days after receipt from your carrier of the payment on a claim or request for coverage of a health care service or treatment, or rescission of coverage.

Should I send any other documents with the Independent Review Form?
Yes. The denial letter you received from your insurance carrier, and a copy of your insurance card. Although not required, you may want to submit any other helpful information for the review organization to evaluate such as medical journal articles or product information.

What do I send to the Department?

Adverse Health Benefit Determination Letter
You will find the reason on the determination letter from the insurance carrier. One of three reasons will be given medical necessity, experimental/ investigational, or rescinded coverage. Use this reason to provide in Section 4 of the *Independent Review Request* (form). The letter will also provide who to contact for the next step in the appeal process. If you have not received a letter, contact your insurance carrier.

Independent Review Request
If you receive an adverse benefit determination from your insurance carrier and the reason is due to medical necessity or experimental/investigational reasons, then you may qualify for an independent review (review). Contractual denials usually do not qualify for a review. If you have a question relating to the reason for denial of coverage, contact your insurance carrier for more information.

Authorization and Appointment
The patient must authorize and release their medical records (see Section 6) in order to start the review. In addition, the patient may want to appoint to disclose the results of the review to their health care provider (see Section 7). If the section is not completed, the results will be sent to the insured.

Expedited Review Request
The treating health care provider can make the determination that your request is urgent and should be completed within 72 hours. The provider should complete an *Expedited Independent Review Certification by Treating Health Care Provider* form (page 5). This applies to concurrent or pre-authorization types of service; not retrospective services or care.

Experimental/Investigational Certification
In addition to the form, an Experimental/ Investigational Independent Review Certification by Treating Physician form (page 4) must be submitted. This form gives the physician an opportunity to provide additional information.

KEEP FOR YOUR RECORDS

https://insurance.utah.gov/consumer/health/independent-review