State Corporation Commission
Bureau of Insurance – External Review
P.O. Box 1157
Richmond, VA 23218
Phone: 1-877-310-6560 Fax: (804) 371-9915
Email: externalreview@scc.virginia.gov

EXTERNAL REVIEW REQUEST FORM

This External Review Request Form must be filed with the Virginia Bureau of Insurance within **120 DAYS** after receipt from your health carrier of a denial of payment on a claim or request for coverage of a health care service or treatment.

Name of Applicant: _____

Applicant is: (check one) □ Covered person/Patient □ Provider □ Authorized Representative
(**NOTE**: Form 216-B must be completed if the applicant is not the covered person.)

Covered Person Information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Phone: Home (_____) _____ Work (_____) _____

Fax: (_____) _____ Email: _____

Insurance Information:

Health Carrier Name: _____

Covered Person Insurance ID#:_____

Insurance Claim/Reference #:_____

Health Carrier Mailing Address: _____

_____

_____

Health Carrier Phone: _____

Employer Information:

Employer's Name: _____

Employer's Phone:(_____) _____

Is the health coverage you have through your employer a self-funded plan? _____.
(If you are not certain please check with your Human Resource office or plan administrator.)

Health Care Provider Information:

Treating Health Care Provider (for the denied services): _____

Address:
_____

_____

_____

Contact Person: _____ Phone: ( ) _____

Reason for Health Carrier Denial (Please check one):

- ☐ The health care service or treatment does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.

- ☐ The health care service or treatment is experimental or investigational (Form 216-D is required).

(**NOTE**: Other reasons for denial are not eligible for external review.)

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

Do not attach medical records at this time. If your appeal is determined to be eligible, you will be notified when and where to submit your medical records and other documentation in support of your appeal.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external review be handled on an expedited basis. You may not request an expedited review if the service has already been provided.
Has the service been provided? Yes_____ No _____

To complete this request, your treating health care provider **must** complete Form 216-C 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.*

Is this a request for an expedited review? Yes_____ No_____

*If you have received a final adverse determination involving emergency services, and you have not yet been discharged from a facility, check here ___. Form 216-C is not required.

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 review. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize the health carrier, any third-party administrator, and the health care providers to release all relevant medical or treatment records to the independent review organization. I understand that the independent review organization will use this information to make a determination on this external review and that the information will be kept confidential and not be released to anyone else. This release is valid until the external review is complete.

_____ _____
Signature of Covered Person (or legal representative*) Date

_____
*Parent, Guardian, Conservator or Other – please specify