



**State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
(804) 371-9913**

INSTRUCTIONS FOR COMPLETING THE APPEAL
OF FINAL ADVERSE DECISION FORM
Please Read Carefully Before Completing the Form

Before completing the attached form, please read the following instructions carefully. We also recommend that you review the form itself as well as the "Important Terms and Definitions" list attached.

The law requires that in order to be "appealable" the actual cost to the covered person of the services or procedures in question exceed \$300 if the final adverse decision is not reversed. Please verify the cost of the service(s) before requesting an appeal of a final adverse decision.

1. Name and Address

Please type (or print) the covered person's full name. Include the address, daytime telephone number, date of birth, sex and policy number, certificate number, or other identifying number of the covered person.

2. Appellant Information

This section is to be completed by the appellant who is making the appeal on behalf of the covered person. This section does not need to be completed if the covered person is requesting the external review on his own behalf.

3. Name of the Managed Care Health Insurance Plan

Please provide the name, address and telephone number of the Managed Care Health Insurance Plan (MCHIP). The MCHIP name should be the same as the insurance company or health maintenance organization providing the covered person's coverage. If the covered person is covered by insurance through an employer, please provide the name, address and phone number of the employer, if available.

4. Describe the Covered Person's Situation

Please clearly and accurately describe the nature of the circumstances surrounding the covered person's request for an appeal of a final adverse decision.

5. Expedited Review

In certain situations, an expedited review of an appeal of a final adverse decision may be requested. Please review the definition of "emergency medical condition" provided with this form. If the situation involves an "emergency medical condition," please indicate this by checking the "yes" box and attach supporting documentation.

6. Treatment for Terminal Conditions

Please indicate whether the requested treatment has already been provided and whether, in the opinion of the covered person's treating health care provider, the covered person's condition would be terminal without this treatment.

7. Filing Fee Waiver

Please note that the \$50 filing fee may be waived. If you wish to request that the filing fee be waived, please describe the reason or reasons for the request and provide supporting documentation.

8. Total Cost of Denied Services

Please provide an estimate of the total cost to you if services remain denied. If a prescription drug has been denied, please estimate the cost for the length of the prescription. This cost estimate is for our records and will not have any bearing on any party's payment responsibility following the final decision.

9. Authorization/Authorization to Release Medical Information

Please carefully read the "Authorization" section on the "Appeal of Final Adverse Decision" form and the separate "Authorization to Release Medical Information" form included with this package. Information that you provide or authorize to be released may be shared with an impartial health entity. The signature of the covered person or other authorized signature is required on both of these forms in order for the appeal of the final adverse decision to occur.



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IMPORTANT TERMS AND DEFINITIONS

"Appellant" - means (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

"Covered person" - means an individual, whether a policyholder, subscriber, enrollee, covered dependent, or a member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for, or reimbursed pursuant to a managed care health insurance plan as defined in and subject to regulation under Chapter 58 (§ 38.2-5800 et seq.) of Title 38.2 of the Code of Virginia, when such coverage is provided under a contract issued in this Commonwealth.

"Cost of Service" - the total amount paid by the covered person for a rendered service or the assumed liability for that service by the covered person for a rendered service. The law requires that in order for an appeal of a final adverse decision to occur, the actual cost to the covered person of the service if the final adverse decision is not reversed must exceed \$300.

"Emergency Medical Condition" - the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. "Emergency medical condition" also means a health condition or illness that if not treated within the time frame allotted for a standard review will result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the covered person's health in serious jeopardy. "Emergency medical condition" also means a health condition that would be terminal without the requested treatment as determined by the person's treating health care provider.

"Expedited Review" - a review of a final adverse decision that is provided in an urgent manner due to the fact that the covered person has an emergency medical condition.

"Final Adverse Decision" - means a utilization review determination: (i) declining to grant an expedited review in a situation involving an alleged emergency medical condition; (ii) declining to provide coverage or services for an alleged emergency medical condition after granting an expedited review; or (iii) denying benefits or coverage, and concerning which all internal appeals available to the covered person pursuant to Title 32.1 of the Code of Virginia have been exhausted. In other words, and except in emergency situations, it is the final decision of the plan after the internal appeal process has been exhausted.

"Impartial Health Entity" - an organization selected by the Bureau of Insurance that performs, under contract with the Bureau of Insurance, reviews of final adverse decisions. The Bureau of Insurance is not an impartial health entity.

"Managed Care Health Insurance Plan" or "MCHIP" - an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with, or employed by the health carrier.



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APPEAL OF FINAL ADVERSE DECISION FORM

If you meet the definition of an **appellant**¹, and have had a request for approval of health care service(s) denied by a **Managed Care Health Insurance Plan (MCHIP)**, you may have the right to an external review of the **MCHIP's** decision. An **impartial health entity** selected by the Bureau of Insurance will review the appropriateness of the **MCHIP's** decision, and make a recommendation to the Commissioner of Insurance as to whether the health care service(s) should be covered. In order for such a review to occur, the **appellant** must complete and sign this form. Additionally, the appeal in question must meet the following criteria:

1. The **cost of service** in question must exceed \$300;
2. The appeal must be filed within 30 days of the **final adverse decision** by the **MCHIP**;
3. The **MCHIP's** internal appeal process must have been exhausted (except for **expedited reviews**); and
4. A \$50 filing fee must be submitted with this form by check or money order made payable to the Treasurer of Virginia. This fee may be waived or refunded if it can be demonstrated that paying the fee constitutes a financial hardship to the **covered person** (see item 7 on the following page); and is refundable if the appeal is not accepted for review.

Additional instructions and definitions of key terms for completing this form are attached. If you have questions while completing this form or if you have questions that are not addressed in the instruction form, you may contact The Office of the Managed Care Ombudsman toll free at (877) 310-6560, or locally at (804) 371-9032, for assistance.

The decision reached as a result of this external review process is binding upon the **covered person** as well as the issuer of the **covered person's** policy to the same extent that each would be bound by a judgment entered in a court action at law or in equity.

I request an external review of the **MCHIP's final adverse decision** by an **impartial health entity** as chosen by the Bureau of Insurance. I certify that the **covered person's MCHIP's** internal appeals have been exhausted, or that the requirements for an **expedited review** have been met.

(Please type or print clearly all requested information in the spaces provided, or use additional pages, if necessary.)

1. Name of the **Covered Person**: _____
 Address: _____

 City: _____ State: _____ Zip: _____
 Daytime Phone Number(s): _____
 Date of Birth: _____ Sex: _____
 ID# (Policy or Certificate Number): _____
2. If you are an **appellant other than the covered person**, please tell us your name and what your relationship is with the **covered person**: _____

¹ Words in bold type are defined key terms.

3. Complete Name of MCHIP: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____

Is this health coverage provided through an employer? Yes No

If yes, please provide the employer's name, address, and telephone number: _____

4. On a separate sheet of paper, please describe the situation you are seeking help with and describe the service(s) or procedure(s) in question:

Please send us a copy of the letter informing the **covered person** of the **MCHIP's final adverse decision**.

5. Are you requesting an **expedited review**? Yes No

If yes, please provide documentation that the **covered person's** situation involves an **emergency medical condition**.

6. a. In the opinion of the covered person's health care provider, is the covered person's condition terminal without this treatment? Yes No If Yes, continue to **b.** If No, skip to question 7.

b. Has the requested treatment already been provided? Yes No If Yes, skip to question 7. If No, continue to **c.**

c. Do you plan to delay the treatment requested while awaiting this external appeal decision? Yes No

7. Are you requesting a waiver of the \$50 filing fee? Yes No

If yes, please provide the reason and documentation to support the claim that paying the \$50 filing fee would cause financial hardship to the **covered person**.

8. The estimated total cost of the denied services to the covered person: \$ _____

AUTHORIZATION

I understand and agree that a copy of this form and any information I provide may be forwarded to the **MCHIP** and to the **impartial health entity**.

Signature of **Appellant** (if not the **Covered Person**)

Date

Signature of **Covered Person** or Other Authorized Signature

Date



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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization must be signed by (i) the covered person; (ii) the covered person's parent, legal guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

Any health care provider of services or supplies, insurance company, or any other organization, institution or person that has a record or knowledge regarding the covered person named below and such person's health, is hereby authorized to furnish to the Bureau of Insurance, or its designated impartial health entity, information concerning services or supplies provided or proposed to be provided to such covered person.

If I am not the covered person listed below, I hereby certify that I am authorized by law to execute this authorization on the covered person's behalf.

This authorization is given for the purpose of conducting an external review of a final adverse decision made by a utilization review entity. This authorization is valid for 90 days from the date below.

Printed Name of Covered Person: _____

Covered Person's Date of Birth: _____

Signature of Covered Person: _____

Date: _____

OR

Other Authorized Signature: _____

Date: _____