External Review Request Form

Your request will be forwarded to the Wyoming Department of Insurance; and must include all the required information and fee as described below. Upon receipt, Mountain Health CO-OP will perform a preliminary review within five (5) days to determine if your request is complete and meets the criteria for an external review. Within one day of our determination, Mountain Health CO-OP will notify you (or your authorized representative) and the Wyoming Department of Insurance if more information is needed, or if your request will be assigned to an Independent Review Organization. You may be eligible for an expedited review if your physician deems it necessary and signs the Certification For Expedited Review portion of this form. Please note the decision made by the independent reviewer will be considered final except to the extent the claimant or insurance carrier has other remedies available under applicable state or federal law.

Eligibility & Requirements: You have the right to an external review **only** if the below criteria are met:

1. The request must be submitted to Mountain Health CO-OP no later than **120 days** from the date of a notice of final denial of benefits for a claim, or request for coverage of a health care service or supply. You must include a photocopy of your insurance identification card with this form.

2. The denial involved the medical necessity of your health care service or supply.

3. You have exhausted the Mountain Health CO-OP's internal appeal process and have received a final denial of benefits (please attach the notice to this form).

4. Your treating health care provider has completed the Health Care Professional Certification of medical necessity (see form provided).

Fees: The Wyoming Department of Insurance requires a $15.00 fee by check or money order, payable to the Wyoming State Treasurer's Office. **Please submit a duplicate copy of this form with payment;** or complete the certification request for fee waiver at the end of this form.

Please note the Mountain Health CO-OP is responsible for the cost of the external review.

Submit this completed form by uploading it in your Member Portal at https://mountainhealthcoop.vbagateway.com/, Sending it via mail to Mountain Health Co-Op, Attn: Member Experience, PO Box 5358, Helena, MT 59604 Or to faxing it to 406-447-5799. Please contact Member Services at 800-299-6080 with questions.

Covered Person/Patient Information

Applicant Name: _____

Applicant is the: ☐ Covered Person ☐ Provider ☐ Authorized Representative

Covered Person Name: _____ ID Number: _____

Patient Name: _____

Mailing Address: _____

Home Phone_____ Work Phone _____

Email: _____

Insurance Information

Insurance Claim Number: _____

SUMMARY OF EXTERNAL REVIEW REQUEST: Write a brief description of the claim, service or treatment that was denied for which you are requesting an external review. Include any additional information that you want the independent review organization reviewer to consider. Attach additional pages if necessary.

Health Care Provider Information

Treating Physician/Health Care Provider: _____

Address: _____

Phone: _____ Contact Person: _____

Medical Record Number: _____

Signature And Release Of Medical Records

To request an external review of your denial, you must sign and date this form and consent to the release of medical records.

I, _____ , hereby request an external review. I attest that the information provided is true and accurate to the best of my knowledge. I hereby authorize that any hospital, physician, osteopath, chiropractor or any other health care provider, or any person, or company, to provide the Wyoming Insurance Department with any medical information or records needed by the Department to investigate my complaint. Additionally, I specifically authorize any provider to release information to the Department about mental health and substance abuse treatment as needed to investigate this complaint. I authorize the Department to share copies of any medical or mental health records or other information

as necessary in order to process my request. This authorization remains in effect for twenty-four (24) months from the date the authorization is signed, or until I revoke it in writing.

_____

Appointment Of Authorized Representative

Fill out this section if someone else will be representing you in this appeal. You can represent yourself, or you may ask another person (including your health care provider) to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Covered Person or Parent/Guardian Date

_____

Mailing Address of Authorized Representative

_____ _____

Phone Email Address

Certification Of Treating Health Care Provider For Consideration Of A Patient's External Review

Note To The Treating Health Care Provider

Patients can request an external review when an insurer has denied a health care service or course of treatment on the basis that the requested health care service or course of treatment does not meet the insurer's requirements for medical necessity or other similar basis. The Wyoming Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by the insurer. Expedited external review is available only if the patient's treating health care provider certified that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to advise the insurer of the medical basis for external review and/or an expedited review.

General Information:

Name of Treating Health Care Provider: _____

Mailing Address: _____

Phone Number_____ Fax Number_____

Name of Patient: _____

Health Care Professional Certification:

I hereby certify that I am the treating health care provider for the above named patient and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is not medically necessary. I understand that in order for the covered person to obtain the right to an external review of this denial, the claimant must show that the covered person's medical treatment is medically necessary.

Wyoming Statute defines 'medical necessity' to mean:

A. A medical service, procedure, or supply provided for the purpose of preventing, diagnosing, or treating an illness, injury, disease or symptom and is a service, procedure or supply that:
   I. Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;

II. Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease, or injury;
III. Is in accordance with professional, evidence-based medicine and recognized standards of good medical practice and care; and
IV. Is not primarily for the convenience of the patient, physician, or other health care provider.

B. A medical service, procedure or supply shall not be excluded from being a medical necessity solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:
I. Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Scient Ltd. for indexing in Excerpta Medicus (EMBASE); or
II. Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t)(2) of the federal Social Security Act.

Please provide a brief statement as to why you believe the proposed medical service or procedure is medically necessary.

The use of the proposed medical service or procedure is supported by:

_____ _____

Treating Health Care Provider's Signature Date

EXPEDITED REQUEST: You may request that your external review be handled on an expedited basis; as quickly as possible without exceeding 72 hours. To be considered, your treating health care provider must fill out the attached Certification For Expedited Review form stating that a delay would seriously jeopardize the life or health of the patient, or the patient's ability to regain maximum function. **Your request will not be considered for expedited review if you do not include the form from your health care provider.**

Is this a request for an expedited External Review? ☐ Yes ☐ No

Certification For Expedited Review:

I hereby certify that I am a treating health care provider for_____ (hereafter referred to as "the patient") and that:

(Check all that apply)

☐ The timeframe for the completion of a standard review would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function;

or

☐ The patient's claim concerns a request for an admission, availability of care, continued stay or health care service for which the patient received emergency services, but has not been discharged from a health care facility.

_____ _____

Treating Health Care Provider's Signature Date

THE STATE OF WYOMING

Insurance Department

Request for Fee Waiver
With External Review Request Form

The request for external review requires the payment of a filing fee of fifteen dollars ($15.00) made payable to the Wyoming State Treasurer. This fee may be waived for indigent persons who complete this Request for Fee Waiver and provide adequate proof of financial hardship.

Any person whose adjusted gross income is below the Federal Poverty Guidelines set forth below shall be granted a fee waiver.

Persons in family	Poverty quideline
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890

For families with more than 8 person, add $4,160 for each additional household member.

Certification of Qualification for Fee Waiver.

I, , herby certify that I am the patient filing an external review request form to review the decision of my insurance company to deny a claim as not being medically necessary. I further certify that based on the above income guidelines I qualify as an indigent person to have the fifteen dollar ($15.00.) filing fee waived. Submitted herewith is a copy of my or my household's most recent income tax return as filed with the Internal Revenue Service.

Signed this ___ day of _____ 20 __

_____

Patient/Covered Person