GlobalHealth

210 Park Ave. | Suite 2800 | Oklahoma City, OK 73102-5621

EXTERNAL REVIEW REQUEST FORM

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Oklahoma Insurance Department within **FOUR (4) MONTHS** after receipt from your health plan of a denial of payment on a claim or request for a health care service or treatment.

APPLICANT NAME: _____

Please Check One: ☐ Covered person/Patient ☐ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Covered Person Phone #: Home (____) _____ Work: (____) _____

HEALTH PLAN INFORMATION

HMO Name: _____GlobalHealth, Inc._____

Covered Person Member ID #: _____

Claim/Reference #: _____

HMO Mailing Address: ____PO Box 2393_____

City: _____Oklahoma City_____ State: ____OK____ Zip: _73101-2393_

HMO Telephone #: (_405_) ___280-XXXX_____

EMPLOYER INFORMATION

Employer's Name: _____

Employer's Phone #: (_____) _____

Is the health benefits plan you have through your employer a self-funded plan? _____. If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address: _____

City: _____ Sate: _____ Zip: _____

Contact Person: _____ Phone #: (____) _____

Medical Record #: _____

REASON FOR HEALTH CARRIER DENIAL (Please check one)*

☐ The health care service or treatment is not medically necessary.

☐ The health care service or treatment is experimental or investigational. The Physician Certification, Experimental/Investigational Denial form will also need to be included.

*You can describe in your own words the health care service or treatment in dispute using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form 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 appeal? ☐ Yes ☐ No

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 appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my health plan and my health care providers to release all relevant medical or treatment records to the independent review organization and the Oklahoma Insurance Department. I understand that the independent review organization and the Oklahoma Insurance Department will use

this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

_____ _____

Signature of Covered Person (or legal representative)* Date
*(Parent, Guardian, Conservator, or Other – Please Specify)

Para los miembros que hablan español:
Si usted no entiende los contenidos de esta carta, por favor llame a Servicios para los Miembros al
1-877-280-5600 y alguien le ayudara.