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|  seal_nj**New Jersey Department of Banking and Insurance The Independent Health Care Appeals Program**  **EXTERNAL APPEAL APPLICATION - MEDICAID**Return Application by mail to: E-mail application to: New Jersey Department of Banking and Insurance ihcap@dobi.nj.gov Office of Managed CareP.O. Box 329Trenton, NJ 08625-0329 (If using courier service: 20 West State Street, 9th Floor)  If you need help completing this application, please call **1-888-393-1062** or **(609) 777-9470.**  |

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| **Section I. MEMBER INFORMATION**  |
| First and Last Name:  | Birthdate: |
| Address (Street, Apt or Suite #, City, State, Zip Code):  |
| Daytime telephone:   | E-mail address:  |
|  **Section II. INSURANCE INFORMATION FOR MEMBER**  |
|  HMO**:**  |
|  ID Number  |  |

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| **Section III. TO BE COMPLETED BY PERSON FILING THE APPEAL** |
|  Name of person filing the appeal:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_  Relationship to the Member: [ ]  Self [ ]  Relative [ ]  Provider [ ]  Advocate  |
|  **If you are a relative, provider or advocate**, please provide your contact information.  Daytime telephone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_ E-mail address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Person if the appeal is filed by a Provider: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Medical Record #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Section IV. SIGNATURE**  |
| 1. **Sign this section if you are filing the appeal yourself or are a relative.**

***CONSENT FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS***I understand that a copy of this form and any enclosures may be sent to the Independent Utilization ReviewOrganization (IURO) and the HMO named in the appeal. I authorize the release of any medical and/or administrative records pertinent to this appeal to the IURO selected by the New Jersey Department of Banking and Insurance.*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Covered Person (Covered person must be 18 years or older) Date* *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Parent or Relative Relationship Date*  |
|  - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - 1. **Sign this section if you are a provider or advocate filing the appeal on behalf of the covered person**

***CONSENT FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS***I am filing as a provider or advocate, acting on behalf of a covered Member with the Member’s consent.To my knowledge and belief, I am authorized to file this application for appeal and to release any pertinent  medical and/or administrative records to the IURO. *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Provider or Advocate Date* *Is a signed Consent form included with the application?* ☐YES ☐ \*NO *\* The appeal cannot be processed until the consent form is received by the Department. A copy of*  *the consent form is included with this application.*  |

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| **V. SUMMARY OF APPEAL** |
| Describe the services denied by your carrier and the reason you believe the HMO’s decision was not correct. Attach a copy of the final written denial, if available.  **Do not send medical records or original documents with this appeal**.  |

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| **EXTERNAL APPEAL APPLICATION INSTRUCTIONS** |
| **You can apply for an External Appeal if:** * Your HMO denied, limited, or delayed a covered treatment, prescription, or service because the HMO decided it is not medically necessary or that it is experimental or investigational.
* You appealed the HMO’s denial to have the decision changed, but the HMO sent you a letter informing you that the service was still denied.

**How to apply for an External Appeal**:1. Complete the External Appeal Application. You can give permission to another person to file the appeal for you. If this person is a health care provider or an advocate, he or she should sign and date the form titled Consent to Representation in Appeals of Utilization Management Determinations and Authorizations for Release of Medical Records in UM Appeals and Independent Arbitration of Claims. This form must be included with the external appeal.
2. Sign and date the External Appeal Application.
3. Include a copy of the letter from the HMO telling you that your appeal was denied.
4. Send the External Appeal Application to the Department by mail or by e-mail within **60 days of the date on the HMO’s letter denying your internal appeal. Do not call the Department to file an external appeal**.
5. If your appeal is urgent, the application can be faxed to the Department at (609) 633-0807

**Do not send medical records to the Department.** If the appeal is accepted for review by the IURO, you will receive a letter from the IURO with instructions on submitting medical records. |

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|  seal_nj**New Jersey Department of Banking and Insurance CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS**  |

 **APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS**

You have the right to ask your HMO to change its utilization management (UM) decision if the HMO decided the service or treatment covered under your health benefits plan is or was not medically necessary. This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

After you complete the HMO’s internal appeal process, you can choose to file an external appeal through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI). Your case will be sent to an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. Your health care provider will share your personal and medical information with DOBI, the IURO, and the IURO’s contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

**CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS**

I, PRINT NAME , by marking √ (orx ) and signing below, agree to:

[ ]  representation by PRINT NAME in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

[ ]  release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: \_ Ins. ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: [ ]  I am the Patient [ ]  I am the Personal Representative (provide contact information on back)

\* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

**Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of this document AFTER it has been completed, signed and dated.**

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|  seal_nj**New Jersey Department of Banking and Insurance NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS**  |

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Your revocation should be sent to:

New Jersey Department of Banking and Insurance

Consumer Protection Services

Office of Managed Care – Attn: IHCAP

P.O. Box 329

Trenton, NJ 08625-0329

OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

 **ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!**

 **REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS**

[ ]  I hereby revoke my consent to representation by and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: \_ Ins. ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: [ ]  I am the Patient [ ]  I am the Personal Representative

**Contact Information of Personal Representative**

Please provide the following contact information IF it is different from the patient’s contact information:

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| PRINT NAME:  |
| Address (Street, Apt or Suite #, City, State, Zip Code):  |
| Telephone:  | FAX:  | E-mail address:       |

 **Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy this document.**