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External Review Application

What you need to send in when applying for an external review

- ☐ Completed request form.
- ☐ Photocopy of insurance identification card.
- ☐ Letter from Director of Employee Benefits or Utilization Review Company that states their decision is final and that all internal review procedures were exhausted or that they waive the requirements to exhaust all internal review procedures.

If you have any questions about completing the request or if you are requesting an expedited external review contact the Bureau of Human Resources at 605.773.3148 before sending your paperwork for the quickest way to submit the request.

South Dakota Division of Insurance
Attn: External Review
124 S. Euclid Avenue
Pierre, SD 57501
Phone: 605.773.3563
Fax: 605.773.5369

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External Review Request Form

South Dakota Division of Insurance
124 S. Euclid Avenue
Pierre, SD 57501-3185
Phone: 605.773.3563, Fax: 605.773.5369
www.state.sd.us/insurance

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Division of Insurance **within FOUR MONTHS after receipt of notice of an adverse determination or final determination and you have exhausted the internal grievance process**. If this is a request for an expedited review please contact the Bureau of Human Resources at 605.773.3148.

Applicant Name	☐ Covered Person ☐ Provider ☐ Authorized Representative				
Date of request					
Type of request ☐ Standard ☐ Expedited					
Covered Person / Patient Information					
Name					
Address					
City		State		ZIP	
Telephone		Fax			
E-mail					
Insurance Company					
Name	SD State Employee Health Plan	Individual or Group Plan	Self-funded group		
Covered Persons Insurance ID					
Insurance Claim/Reference #					
Address	500 E. Capitol Ave				
City	Pierre	State	SD	ZIP	57501
Insurer contact	Corinne Chapinski				
Telephone	605.773.3148	Fax	605.773.6840		
E-mail	BHR.memberbenefits@state.sd.us				
Employer Information					
Name	State of South Dakota	Phone	605.773.3148		
Is the health coverage you have through your employer a self-funded plan? X YES ☐ NO If you are not certain please check with your employer.					
Health Care Provider Information					
Name					
Address					
City		State		ZIP	
Contact Person					
Telephone		Fax			
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.

☐ Other:

Summary of External Review Request

You may attach a copy of the denial from your health carrier or describe in your own words the health care service or treatment in dispute and why you are appealing this denial. You may attach additional pages if there is not enough space.

Please provide all of the following information you want the Independent Review Organization to consider.

- Available pertinent medical records
- Information received from your health company concerning the denial
- Pertinent peer literature or clinical studies
- Any additional information from your healthcare provider

Appointment of Authorized Representative
Fill out this section only if someone else will be representing you in this appeal.

You can represent yourself, or may ask another person, including your treating 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.

Address					
City		State		ZIP	
Telephone		Fax			
E-mail					

_____ _____ _____
Signature of Covered Person or legal representative (POA) Parent, Guardian, Conservator or Other Date

_____ _____
Signature of Authorized Representative Date

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 insurance carrier and health care providers to release all relevant medical or treatment records to the Independent Review Organization and the South Dakota Division of Insurance. I understand that the Independent Review Organization and the South Dakota Division of Insurance will use this information to make a determination on my external appeal, and that the information will be kept confidential and will not be released to anyone else. This release is valid for one year.

_____ _____ _____
Signature of Covered Person or legal representative Parent, Guardian, Conservator or Other Date