

CHECK LIST

South Dakota External Review Application

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

- Completed request form.
- \$25 application fee payable to SD Division of Insurance (check or money order).
- Photocopy of insurance identification card or other evidence of coverage by the health insurance company named in the application.
- Letter from health insurance company 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.
- Copy of certificate of coverage or insurance policy benefit booklet, which lists the benefits under my health benefit plan.

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

South Dakota Division of Insurance
Attn: External Review
124 S. Euclid Ave., 2nd Floor
Pierre, SD 57501
Phone: 605.773.3563
Fax: 605.773.5369
insurance@state.sd.us

External Review Request Form

South Dakota Division of Insurance
 124 S. Euclid Ave., 2nd Floor
 Pierre, SD 57501-3185
 Phone: 605.773.3563, Fax: 605.773.5369
<http://dlr.sd.gov/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 Division of Insurance at 605.773.3563.

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	Individual or Group Plan	
Covered Persons Insurance ID		
Insurance Claim/Reference #		
Address		
City	State	ZIP
Insurer contact		
Telephone	Fax	
E-mail		

Employer Information

Name	Phone	
Is the health coverage you have through your employer a self-funded plan? <input type="checkbox"/> YES <input type="checkbox"/> 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 #				

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 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

For Use with Experimental/Investigational Denials Only To Be Completed by Physician

**In my medical opinion as the Insured's treating physician, I hereby certify to the following:
Please check all that apply.**

1. The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

2. The covered person has a condition that qualifies under one or more of the following:

Standard health care services or treatments have not been effective in improving the covered person's condition;

Standard health care services or treatments are not medically appropriate for the covered person; or

There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

3. The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

4. The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explain: _____

5. It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Explain: _____

6. Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. Attach additional sheets as necessary.

Physician's Signature

Date