Pennsylvania Insurance Department

Request a Review of Denied Health Insurance Claims

If your health plan has denied a service, treatment, or item, you may be eligible to request a review of the decision. If the review determines that the request should be covered, your health plan must do so. If your life or health is at serious risk, please select an Expedited Independent External Review in your application.

More information on Independent External Reviews: https://iro.insurance.pa.gov

To apply for an Independent External Review, you must include the following documents:

- A 'Final Adverse Benefit Determination Letter,' a denial letter from your health plan
- Your insurance card
- Any medical records or materials that show why the request should be covered

For Expedited Independent External Reviews, your doctor must also complete a Physician Certification (this document is available on our website).

Personal Information

Complete the following information for the member, the person whose service was denied.

Member's Name: _____ **Date of Birth:** _____
Name of Member's Legal Guardian (optional): _____
Address of Member (or Legal Guardian): _____
_____
_____
Primary Phone Number: _____ **Secondary Phone Number:** _____
Email: _____

Pennsylvania Insurance Department

Health Insurance Plan Information

This information will be used to confirm your eligibility for an Independent External Review.

Name of Insurer: _____

Health Insurance Plan: _____

Subscriber or Member ID Number: _____

* This number is listed on the front of the membership identification card provided to you by your health insurance provider.

Insurance Claim/Reference Number: _____

* This number will be provided in response to the internal appeal you submitted to your health insurance.

Health Care Decision Dispute

This information is needed for your insurer to match your request to the correct claim. You may be eligible to receive a faster decision if your life, health, or ability to regain maximum function would be jeopardized by the standard 45-day review.

Date of Insurer Decision: _____

Service Denied: _____

Do you or your doctor think this was a medical emergency? ☐ **Yes** ☐ **No**

*If yes, have your provider complete the physician certification and include with request.

If any of your health care providers will be involved with this external review, please complete the following section:

Name of Health Care Provider: _____

Type of Provider: ☐**Medical Doctor** ☐**Other (Please Specify):** _____

Provider Mailing Address: _____

_____

_____

Provider Phone Number: _____

Pennsylvania Insurance Department

In Your Own Words

Please describe why you disagree with your insurer's decision. Please include any details that you feel may help us understand your unique situation. Do not include sensitive information such as a Social Security number. Attach additional pages if necessary.

Member Representation

Fill Out This Section Only if Someone Will Be Representing You in This Appeal

You can have a family member, friend, lawyer, or other person represent you or act on your behalf. You or your representative may ask your insurer about the medical service that is the subject of your independent external review.

Send member:

☐Correspondence Documents

☐Medical Records and Other Documents

Send Representative:

☐Correspondence Documents

☐Medical Records and Other Documents

I hereby authorize _____ to pursue this external review on my behalf and not (by this authorization) for any other purpose.

Representative's Address: _____

_____

_____

Representatives Primary Phone Number: _____

Secondary Phone Number: _____

Email: _____

Pennsylvania Insurance Department

Consent to Release and Exchange Information

I, _____, hereby request an external review of an adverse benefit determination and authorize the Pennsylvania Insurance Department to obtain copies of my medical records and all other information necessary for this review. The Department has my permission to release and exchange this information with my health insurer and an independent review organization certified by the Department, and with any health care provider or personal representative designated on this application form.

☐In addition, though I do not have a representative, I want the Department to be able to release and exchange all information related to this review with:

_____

_____ _____

Signature of Member or Legal Guardian Date

Filing Instructions

Applications can also be completed online: https://iro.insurance.pa.gov

Completed applications and any supporting information may be submitted by:

Fax: 717-231-7960

Email: RA-IN-ExternalReview@pa.gov

Mail: Pennsylvania Insurance Department
Attn: Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120