STATE OF WYOMING
INSURANCE DEPARTMENT

106 East 6th Avenue
Cheyenne, WY 82002
Phone: (307) 777-7401
Fax: (307) 777-2446
http://doi.wyo.gov

EXTERNAL REVIEW REQUEST CHECKLIST

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. ☐ YES, I have included the completed application form signed and dated.

2. ☐ YES, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;

3. ☐ YES, I have enclosed the letter from my insurer or utilization review company that states:
   (a) Their decision is final and that I have exhausted all internal review procedures; or
   (b) They have waived the requirement to exhaust all of the insurer's internal review procedures; or
   (c) My health care professional has certified my condition as requiring an expedited review and his certification is attached hereto.

4. ☐ YES, I have included the fee of fifteen dollars ($15.00) by check or money order payable to the Wyoming State Treasurer's Office or I have completed the certification request for fee waiver.

*Call the Insurance Department at (307) 777-7401 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

Send all paperwork, including a duplicate copy, with the required filing fee to: [insert address where paperwork should be mailed].

EXTERNAL REVIEW REQUEST FORM

This EXTERNAL REVIEW REQUEST FORM must be filed with your insurer/HMO within one hundred twenty (120) days after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment. This request must be accompanied by a fifteen dollar ($15.00) fee in the form of a check or money order payable to the Wyoming State Treasurer.

APPLICANT NAME: _____

☐ Covered person/Patient ☐ Provider ☐ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____ ID No. _____

Patient Name: _____

Address: _____

Covered Person Phone No.: Home (_____) _____ Work (_____) _____

INSURANCE INFORMATION

Insurer/HMO: _____

Insurance Claim/Reference No.: _____ Insurer Phone No. : (_____) _____

Insurer/HMO Mailing Address: _____

_____

Is the health coverage you have through your employer a self-funded plan? ☐ Yes ☐ No

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: _____

_____

Contact Person: _____ Phone:(_____) _____
Medical Record No.: _____

SUMMARY OF EXTERNAL REVIEW REQUEST Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your insurer.

_____
_____
_____
_____
_____
_____

EXPEDITED APPEAL OR REVIEW

If you need a fast decision, you may request that your external review 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 external review? ☐ Yes ☐ No

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To request an external review of your insurer'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 company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Wyoming Insurance Department. I understand that the independent review organization and the Wyoming 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)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you 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.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative: _____

_____

Phone No. : Daytime (____) _____ Evening (____) _____

CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when an insurer has denied a health care service or course of treatment on the basis that the requested health care service or course of treatment does not meet the insurer's requirements for medical necessity or other similar basis. The Wyoming Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by the insurer. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to advise the insurer of the medical basis for external review and/or an expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

Phone Number: (____) _____ Fax Number: (____) _____

Name of Patient: _____

HEALTH CARE PROFESSIONAL CERTIFICATION (To Be Completed by Treating Health care professional)

I hereby certify that I am the treating health care professional for _____ (covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is not medically necessary. I understand that in order for the covered person to obtain the right to an external review of this denial, the claimant must show that the covered person's medical treatment must be considered medically necessary.

Wyoming Statute defines "Medical necessity," to mean:

(A) A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:

(I) Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;

(II) Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury;

(III) Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care; and

(IV) Is not primarily for the convenience of the patient, physician or other health care provider.

(B) A medical service, procedure or supply shall not be excluded from being a medical necessity solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:

(I) Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or

(II) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

Please provide a brief statement as to why you believe the proposed medical service or procedure is medically necessary.

_____

_____

_____

The use of the proposed medical service or procedure is supported by:

_____

_____

_____

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date

CERTIFICATION FOR EXPEDITED APPEAL OR EXPEDITED REVEIW

I hereby certify that: I am a treating health care provider for _____
(hereafter referred to as "the patient") and that:

(check all appropriate)

☐ The timeframe for the completion of a normal review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

☐ The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date

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Request for Fee Waiver
With External Review Request Form

The request for external review requires the payment of a filing fee of fifteen dollars ($15.00) made payable to the Wyoming State Treasurer. This fee may be waived for indigent persons who complete this Request for Fee Waiver and provide adequate proof of financial hardship.

Any person whose adjusted gross income is below the Federal Poverty Guidelines set forth below shall be granted a fee waiver.

Persons in family	Poverty guideline
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890

For families with more than 8 person, add $4,160 for each additional household member.

Certification of Qualification for Fee Waiver.

I, , herby certify that I am the patient filing an external review request form to review the decision of my insurance company to deny a claim as not being medically necessary. I further certify that based on the above income guidelines I qualify as an indigent person to have the fifteen dollar ($15.00.) filing fee waived. Submitted herewith is a copy of my or my household's most recent income tax return as filed with the Internal Revenue Service.

Signed this day of_____, 20 .

_____
Patient/Covered Person