A Qualified Health Plan Issuer on the Health Insurance Marketplace

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INTERNAL APPEAL REQUEST FORM (Indiana)

Name of person filing appeal: _____

Relationship to covered person: ❒Covered Person/Applicant

❒Authorized Representative ***(please complete the Appointment of Authorized Representative section)***

How would you like us to contact you? ❒Phone ❒Fax ❒Email ❒Mail

Contact information of authorized representative (if applicable)

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

Covered Person/Applicant Information

Name: ID Number:

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

Treating Physician/Health Care Provider Information

Name:

Mailing Address: Phone Number:

Email Address: Fax Number:

Contact Person: Phone Number:

Internal Appeal Specifications

1. Are you requesting an Expedited Internal Appeal because review under the standard Internal Appeal time frame (of up to 45 days) could, in the absence of immediate medical attention, result in placing your life or health in serious jeopardy, seriously affect your ability to reach and maintain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is subject to this Appeal?

   ❒YES* ❒NO

2. Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review because adherence to the standard time frame for conducting an Expedited Internal Appeal of rending a decision within 72 hours from the date of request, in the absence of immediate medical attention, could seriously jeopardize your life or health, could seriously jeopardize your ability to reach and maintain maximum function, or your Appeal is related to a claim involving Emergent Care and a Concurrent Care claim?
   ❒YES* ❒NO

***If you answer YES to any of the questions above, your treating provider should complete the Treating Provider Opinion Form for Internal Appeal and/or External Review.**

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

_____

_____

Appointment of Authorized Representative (complete when someone else is representing you in this Appeal)

You may represent yourself, or you may ask another person, including your treating provider, to act as your authorized representative. You may revoke this authorization at any time.

I**, [Insert Name of Member**] _____, appoint **[Insert Name of Authorized**

Representative] _____**,** to act on my behalf in connection with any claim for coverage or benefits identified in this case, including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me and to provide any information to the health plan in relation to the disputed claims, approvals, or authorizations.

_____

Signature of Covered Person (or legal representative*) Date

*Parent, Guardian, Conservator, Other—please specify

I,**[Insert Name of Authorized Representative],** hereby accept the above appointment. I am a/an [**Insert Relationship to Member**].

_____

Signature of Authorized Representative Date

Consent to Release Medical Records

To request an Internal Appeal and/or an External Review of your Adverse Benefit Determination, whether expedited or not, you must sign and date this form and consent to the release of your medical records.

I, _____, hereby request an Internal Appeal and/or External Review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, health care provider, and/or health plan issuer to release all relevant medical or treatment records to the Independent Review Organization, the Indiana Department of Insurance, and/or my health plan issuer. I understand that the Independent Review Organization and/or my health plan issuer will use this information to make a determination on my Internal Appeal and/or External Review and that the information will be kept confidential and not be released to anyone else. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

_____

Signature of Covered Person (or legal representative**) Date

**Parent, Guardian, Conservator or Other - please specify

SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING ADDRESSES:

Fax Number: **1-866-582-0613**

Email Address: **HIXING&A@caresource.com**

Mailing Address: CareSource, Attn: Grievance & Appeals, P.O. Box 1947, Dayton, OH 45401-1947

Be certain to keep copies of this form, your Notice of Adverse Benefit Determination, and all documents and correspondence related to this claim.

If you need help with this form, please call our Member Services department at **1-877-806-9284**, from 7:00 a.m. to 7:00 p.m., Monday through Friday.

IN-EXCM-0016b