STATE OF ALASKA
DIVISION OF INSURANCE
550 West 7th Avenue, Suite 1560 Anchorage, AK 99501-3567
Telephone: (907) 269-7900 Fax: (907) 269-7910 TTY/TDD: 711 or (800) 770-8973
Consumerservices@alaska.gov

EXTERNAL REVIEW APPLICATION FORM

*For expedited (emergency) reviews, follow instructions in **Section V***

For additional information about the External Review process, please review the Guide to External Healthcare Review on our website or contact the Alaska Division of Insurance.

*****We are unable to process incomplete applications*****

Applications that are not adequately completed will be returned.

***Note**: **This form will not be accepted from Providers.**
Please only use this form if you are the covered person/patient,
or the parent/legal guardian of a minor covered person/patient.

Section I – Covered Person/Patient Information

Covered Person/Patient Name: _____ Date of Birth:_____
Mailing Address: _____ City: _____
State: _____ Zip Code: _____ Email: _____
Daytime Phone: _____ Evening Phone: _____

Please complete if the covered person/patient is under age 18 **and** provide proof of legal relationship:
Name: _____ **parent** ☐ or **legal guardian** ☐
Mailing Address: _____ City: _____
State: _____ Zip Code: _____ Email: _____
Daytime Phone: _____ Evening Phone: _____

Section II – Insurance Plan Information

Health Insurance Company: _____
Mailing Address: _____ City: _____
State: _____ Zip Code: _____ Email: _____
Daytime Phone: _____ Fax Number: _____
(If more than one insurance company is involved with your claim, please attach contact information)

Primary Insured/Policy Holder Name: _____
Policy Number: _____ Claim/Reference Number: _____

If the insurance plan is provided through an employer/retiree plan, please provide:
Employer Name: _____ Daytime Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Is the employer's plan self-funded? * Yes: _____ No: _____
***Self-funded plans are not eligible for external review through the Division of Insurance.**

Section III – Information about the Patient's Healthcare Provider

Name of Treating Healthcare Provider: _____

Clinical Specialty: _____

Treating Provider's Contact Person: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Daytime Phone: _____ Fax Number: _____

Section IV – Healthcare Decision in Dispute

Explain below why you disagree with the insurance company. Describe in your own words the information about the healthcare services, supplies, or drugs being denied.

Your Explanation: (Sign each additional page)

Section V – Certification of Treating Healthcare Provider

Does your request relate to experimental/investigational treatment? Yes:_____ No:_____

Do you request an **expedited review**? Yes: _____ No: _____

Important: To request **expedited review**, the applicant must effectively demonstrate that delayed treatment would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

If you selected **YES to either above**, provide the **required** "Certification of Treating Healthcare Provider" form available on our website under Consumers, Health Insurance External Review or https://www.commerce.alaska.gov/web/ins/Consumers/Health/ExternalHealthcareReview.aspx

Section VI – Authorization and Release of Medical Records

To request this review, you must sign and date the consent to release of medical records.

I, _____, hereby request an external review and authorize the covered person's insurance company and healthcare providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the Alaska Division of Insurance (DOI). If approved for external review, I understand that the IRO and the DOI will use this information to make a determination to either reverse or uphold the insurer's determination. I also understand that the information will be kept confidential. I further understand that neither the Director nor the IRO may authorize services in excess of those covered by the patient's healthcare plan. Unless revoked, this release is valid for one year. I attest that the information provided in this application is true and accurate to the best of my knowledge.

I am the: Covered Person/Patient: _____ / Parent or Legal Guardian*: ____
***Attached documentation supporting legal relationship.**

X _____ _____
Signature Date

Application Checklist

Before submitting this application, please…

☐ Complete all relevant sections of the External Review Application Form.
- If requesting an Expedited External Review, Section V must be completed and the Provider Certification Form must be submitted.

☐ Sign and date the Authorization and Release of Medical Records above.

☐ Attach the following documents in support of your request:
- A copy of the covered person's insurance card or other evidence that the covered person is insured by the health or dental insurance company named in the request.
- A copy of the health insurance company's explanation of benefits, grievance determination, and all related documents to illustrate that you have exhausted the insurance company's internal grievance procedures (appeal process) regarding the final adverse determination that you would like to have externally reviewed.
- Any medical records, statements from the treating healthcare provider(s), or other information that you would like the Independent Review Organization (IRO) to consider during the external review.