OHIO DEPARTMENT OF INSURANCE
MODEL CONTRACTUAL EXTERNAL REVIEW REQUEST CONFIRMATION NOTICE

HEALTH PLAN ISSUER: **DATE OF NOTICE:**

MAILING ADDRESS:

TELEPHONE: **FAX:**

WEBSITE/EMAIL ADDRESS:

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION THAT YOU SHOULD RETAIN FOR YOUR RECORDS

This notice is to confirm that your request for a non-expedited external review of a contractual adverse benefit determination was received on the date shown below and that your request is complete and eligible for external review by the Ohio Department of Insurance.

DATE YOUR EXTERNAL REVIEW REQUEST WAS RECEIVED:	ODI CASE NUMBER:

- We will forward all documents and information considered in making the adverse benefit determination to the Ohio Department of Insurance.
- You may also submit in writing any additional information you or your treating physician believe may assist the Ohio Department of Insurance in their review. Any additional information must be sent directly to the Ohio Department of Insurance at their mailing address or fax number provided below within 10 days of the date you received this notice. **Be sure to attach a copy of this notice to any additional information you send.** It is also important to reference the ODI Case Number provided above in all correspondence relating to your external review.
- You will be notified of the review decision directly by the Ohio Department of Insurance.
- Please contact us if you have questions regarding the information provided in this notice.
- For further assistance you may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: External Review Unit
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)