

**OHIO DEPARTMENT OF INSURANCE
MODEL REQUEST FOR APPEAL OF EXTERNAL REVIEW REQUEST DENIAL**

You have the right to appeal our decision to deny your request for an external review to the Ohio Department of Insurance. To request an appeal of our decision, complete this form and returned it with a copy of your Notice of Denial of External Review Request to us at one of the following:

Fax Number:

Email Address:

Mailing Address:

Name of person filing request for review by the Ohio Department of Insurance:

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:

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Review Specifications

Briefly describe why you disagree with our decision to deny your request for external review (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 health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my review by the Ohio Department of Insurance on my behalf.

Signature of Covered Person (or legal representative*)

Date

Signature and Release of Medical Records

To appeal the external review denial, you must sign and date this Request for Review by the Ohio Department of Insurance Form and consent to the release of medical records.

I, _____, hereby request a review of the external review denial. 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 Ohio Department of Insurance. I understand that the Ohio Department of Insurance will use this information to make a determination on my request for review of the denial and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. 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*

Be certain to keep copies of this form, your Notice of Denial of External Review Request and all documents and correspondence related to this review.