Wellmark Administrators, Inc.
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External Review Request Form

Farm Bureau Health Plan
c/o Wellmark Administrators, Inc.
Special Inquiries, Mail Station 5W189
PO Box 9232
Des Moines, IA 50306-9232

Date of request_____/_____/_____

This **External Review Request Form** must be filed with Farm Bureau Health Plan (FBHP) within four months after receipt of notice of an adverse determination or final determination and you have exhausted the internal grievance process. If this is a request for an expedited review please fax the completed request to 515-376-9073.

Type of request: ☐ Standard ☐ Expedited

☐ Covered Person ☐ Provider ☐ Authorized Representative

A. Applicant Information

Applicant Name_______________

Address_______________

City_______________ State_______________ ZIP_______________

Phone Number (_____)_______________ Fax Number (_____)_______________

Email Address _______________

B. Covered Person / Patient Information

Name_______________

Address_______________

City_______________ State_______________ ZIP_______________

Phone Number (_____)_______________ Fax Number (_____)_______________

Email Address_______________

Covered Person's ID_______________

Claim/Reference #_______________

C. Health Care Provider Information

Name_______________

Address_______________

City_______________ State_______________ ZIP_______________

Contact Name_______________

Phone Number (_____)_______________ Fax Number (_____)_______________

Medical Record #_______________

D. Reason for Denial (Please check one)

☐ The health care service or treatment is not medically necessary

☐ The health care service or treatment is experimental or investigational

☐ Other: _______________

E. Summary of External Review Request

You may attach a copy of the denial from your health benefit plan or describe in your own words the health care service or treatment in dispute and why you are appealing this denial. You may attach additional pages if there is not enough space.

Please provide all of the following information you want the Independent Review Organization to consider.

- Available pertinent medical records
- Information received from your health benefit plan concerning the denial
- Pertinent peer literature or clinical studies
- Any additional information from your health care provider

F. Appointment of Authorized Representative (Fill out this section only if someone else will be representing you in this appeal)

You can represent yourself, or 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.

Address____

City______________________________ State__________ ZIP____________

Phone Number (_____)__________ Fax Number (_____)__________

Email Address____

Signature of Covered Person or Legal Representative (POA)______________________ Date _____/_____/_____

Signature of Parent, Guardian, Conservator or Other______________________ Date _____/_____/_____

G. Signature and Release of Medical Records

To appeal your 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 health benefit plan and providers to release all relevant medical or treatment records to the Independent Review Organization. I understand that the Independent Review Organization will use this information to make a determination on my external appeal, and that the information will be kept confidential and will not be released to anyone else. This release is valid for one year.

Signature of Covered Person or Legal Representative (POA)______________________ Date _____/_____/_____

Signature of Parent, Guardian, Conservator or Other______________________ Date _____/_____/_____

H. For Use with Expedited Review Only - To Be Completed by Physician

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when benefits for a service or course of treatment is denied on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. Wellmark Administrators, Inc. will monitor all external reviews sent to our office, as the external review is conducted by an independent review organization. The standard external review process can take up to 45 days from the date the patient's request for external review is received. 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 within 72 hours. **This form is for the purpose of providing the certification necessary to trigger expedited review.**

I. General Information

Name of Treating Health Care Provider____

Address____

City______________________________ State__________ ZIP____________

Contact Name____

Phone Number (_____)__________ Fax Number (_____)__________

Email Address____

Licensure/Area of Clinical Specialty____

Name of Patient____

Covered Person's ID____

J. Certification

I hereby certify that: I am a treating health care provider for______________________________, hereafter referred to as "the patient"; that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Name (Please print)____

Signature____ Date _____/_____/_____

K. For Use with Experimental/Investigation Denials Only - To Be Completed by Physician

In my medical opinion as the Covered Person's treating physician, I hereby certify to the following (please check all that apply):

1. ☐ The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

2. ☐ The covered person has a condition that qualifies under one or more of the following:

   ☐ Standard health care services or treatments have not been effective in improving the covered person's condition;

   ☐ Standard health care services or treatments are not medically appropriate for the covered person; or

   ☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

3. ☐ The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

4. ☐ The health care service or treatment recommended would be significantly less effective if not promptly initiated.

   Explain:

5. ☐ It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.

   Explain:

6. ☐ Please provide a description of the recommended or requested health care service or treatment that is the subject of denial. Attach additional sheets as necessary.

Physician's Signature____ Date _____/_____/_____