External Review Request Form

Wellmark Blue Cross and Blue Shield of South Dakota
Member Appeals, Station 351
P.O. Box 5023
Sioux Falls, SD 57117-5023

This **EXTERNAL REVIEW REQUEST FORM** must be filed with Wellmark Blue Cross and Blue Shied of South Dakota **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 contact Wellmark at 1-800-831-4818.

Applicant Name ☐ Covered Person ☐ Provider ☐ Authorized Representative					
Date of request					
Type of request ☐ Standard ☐ Expedited					
Covered Person / Patient Information					
Name					
Address					
City		State		ZIP	
Telephone		Fax			
E-mail					
Insurance Company					
Name		Individual or Group Plan			
Covered Persons Insurance ID					
Insurance Claim/Reference #					
Address					
City		State		ZIP	
Insurer contact					
Telephone		Fax			
E-mail					
Employer Information					
Name		Phone			
Is the health coverage you have through your employer a self-funded plan? ☐ YES ☐ NO If you are not certain please check with your employer.					
Health Care Provider Information					
Name					
Address					
City		State		ZIP	
Contact Person					
Telephone		Fax			
Medical Record #					

Reason for Health Carrier 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:

Summary of External Review Request
You may attach a copy of the denial from your health carrier 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 company concerning the denial
- Pertinent peer literature or clinical studies
- Any additional information from your healthcare provider

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	
Telephone		Fax			
E-mail					

_____ _____ _____
Signature of Covered Person or legal representative (POA) Parent, Guardian, Conservator or Other Date

Signature and Release of Medical Records

To appeal your health carrier's 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 insurance carrier and health care 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 Parent, Guardian, Conservator or Other Date

For Use with Experimental/Investigational Denials Only
To Be Completed by Physician

In my medical opinion as the Insured'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 the denial. Attach additional sheets as necessary.

_____

_____

_____

_____ _____

Physician's Signature Date