

Model Notice of Final Internal Adverse Benefit Determination –Revised as of [Insert date]

**Date of Notice**  
**Name of Plan**  
**Address**

**Telephone/Fax**  
**Website/Email Address**

**This document contains important information that you should retain for your records.**

This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal (see the back of this page for information about your appeal rights).

**Internal Appeal Case Details:**

<b>Patient Name:</b>				<b>ID Number:</b>			
<b>Address: (street, county, state, zip)</b>							
<b>Claim #:</b>				<b>Date of Service:</b>			
<b>Provider:</b>							
<b>Reason for Upholding Denial (in whole or in part):</b>							
<b>Amt. Charged</b>	<b>Allowed Amt.</b>	<b>Other Insurance</b>	<b>Deductible</b>	<b>Co-pay</b>	<b>Coinsurance</b>	<b>Other Amts. Not Covered</b>	<b>Amt. Paid</b>
<b>YTD Credit toward Deductible:</b>				<b>YTD Credit toward Out-of-Pocket Maximum:</b>			
<b>Description of Service:</b>				<b>Denial Codes:</b>			

*[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]*

**Background Information:** *Describe facts of the case including type of appeal and date appeal filed.*

**Final Internal Adverse Benefit Determination:** *State that adverse benefit determination has been upheld. List all documents and statements that were reviewed to make this final internal adverse benefit determination.*

**Findings:** *Discuss the reason or reasons for the final internal adverse benefit determination.*

**[Insert language assistance disclosure here, if applicable.**

SPANISH (Español): Para obtener asistencia en Espanol, llame al [insert telephone number].  
 TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].  
 CHINESE [Insert Chinese characters]  
 NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].

**What if I need help understanding this denial?**

Contact [Plan name, contact info] if you need assistance understanding this notice or our decision to deny you a service or coverage.

**What if I don't agree with this decision?**

You are entitled to request an independent, external review of our decision. Contact the U.S. Office of Personnel Management (OPM) toll free at 1-855-318-0714 with any questions about your right to request external review of this decision. Information is also available on the web at <http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>. You may also contact OPM at [mspp@opm.gov](mailto:mspp@opm.gov) or via postal mail at:

**MSP Program External Review  
National Healthcare Operations  
U.S. Office of Personnel Management  
1900 E Street, NW  
Washington, DC 20415**

Please see the section “Other resources to help you” on this page if you need help filing a request for external review.

**What if my situation is urgent?**

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one that concerns an admission, availability of care, continued stay, or health care service for which you have received emergency services, but have not been discharged. A situation is also urgent if the standard External Review time frame would seriously jeopardize your life, health, or ability to regain maximum function. You may request an expedited external review by contacting OPM via toll free phone, email, or postal mail as noted above.

**Who may file a request for external review?**

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by completing an Authorized Representative Form.

**Can I provide additional information about my claim?**

Yes. After you have filed your request for external review, you will receive instructions on how to supply additional information.

**Can I request copies of information relevant to my claim?**

Yes. You may request copies (free of charge) by contacting [Plan name, contact info].

**What happens next?**

If you file a request for external review, OPM will review our decision. If your claim was denied as not medically necessary, OPM will seek the binding opinion of an independent review organization. If your claim was denied based on coverage under your plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn our decision, we will provide coverage or payment for your health care item or service.

**Other resources to help you:**

For questions about your rights, this notice, or for assistance, you can contact OPM toll free at 1-855-318-0714. You can also learn more at <http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>. Additionally, a [consumer assistance program, ombudsman's office, or consumer complaints department] can help you file your appeal. Contact [name of program/office] at [contact info].

## **Privacy Act Statement**

In order to conduct an external review of your denied claim, the U.S. Office of Personnel Management (OPM) requires you to submit this form. Provision of this information is voluntary, but if you omit information that is necessary to decide your external review it is possible that your external review may not be conducted or may be decided adversely.

OPM will use your information to determine whether you are eligible for external review, to conduct your external review, to provide you or your insurer with a record of the external review, and for general management of the external review system, including OPM's tracking and reporting on the external review system. Other possible routine uses of your records include the following:

- Disclosure to agency contractors, such as Independent Review Organizations, for the purpose of conducting external review;
- Responses to congressional inquiries initiated by you;
- Investigations of potential violations of law, and judicial or administrative proceedings to which the Federal Government is a party (the information may be provided to another agency, a court, an administrative body, or to the Department of Justice, when the information is arguably relevant to the proceeding);
- Investigations of data breaches and responses to data breaches;
- Disclosure to the National Archives and Records Administration (NARA) or the General Services Administration (GSA) for records management purposes;
- Disclosure to program and policy staff within OPM for statistical and analytical studies or to assist in formulating health program changes; and
- Disclosure to researchers inside and outside of the Federal Government, approved in advance by OPM on the basis of demonstrated aptitude and a written research plan, conducting research on insurance trends and topical issues.

OPM has the authority to administer the Multi-State Plan Program under section 1334 of the Affordable Care Act (42 U.S.C. 18054).

Your Social Security Number (SSN) may be disclosed to OPM on some of the documents that you, your health care provider, or your insurance plan may submit as part of an appeal to OPM. OPM will send a copy of any information you send to OPM to the health insurance issuer that is involved in the relevant dispute. This may include documents containing your SSN. OPM may need your SSN to identify your unique records as authorized by Executive Order 9397. Although disclosure of your SSN is not mandatory, your failure to disclose it when requested by OPM may prevent or delay the review.

## **Public Burden Statement**

We estimate this form takes an average of 5 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, National Healthcare Operations, 1900 E Street, NW, Washington, DC 20415-3430. The OMB Number 3206-XXXX is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.