OMB Control Number 3206-0263

United States
Office of
Personnel Management
The Federal Government's Human Resources Agency

Multi-State Plan Program

External Review Intake Form

Instructions

If you are enrolled in a Multi-State Plan (MSP) option and your claim has been denied by your insurance company, you may use this form to ask the U.S. Office of Personnel Management (OPM) to independently review that denial. This process is called External Review and is free of charge to all enrollees.

Upon request, OPM will review whether your insurance company's denial was justified by examining the terms of coverage and the specific circumstances surrounding the denial. If medical expertise is needed for review of a denial, OPM will seek the opinion of a contracted Independent Review Organization (IRO). In most cases, OPM will communicate a decision within 30 days.

Except in certain circumstances, you will have to exhaust whatever appeal process your insurance company provides before you can ask OPM for External Review. If your insurance company has not responded to your request for an appeal generally within 30 days, or if you are denied emergency services, or if your doctor has determined that the denial of care would seriously jeopardize your life or jeopardize your ability to regain maximum function, you may be able to request External Review without first exhausting your insurance company's appeal process. In that case, OPM generally will communicate a decision within 72 hours.

To file a request for External Review

1) Complete this External Review Intake Form and, if applicable, the Authorized Representative Form (see below for more information about authorized representatives).
2) Submit them to OPM via email at mspp@opm.gov or via fax at (202) 606-0033, or mail them to OPM at:

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

3) You may call OPM toll free at (855) 318-0714 if you need help with your request for External Review.

The following documents and information will help you complete the External Review Intake Form:

- **The letter from your insurance company stating that the company has denied your appeal.** This may not be required if you are requesting External Review for emergency services or if your doctor has determined that the denial of care would seriously jeopardize your life or jeopardize your ability to regain maximum function.
- Member identification number and plan name located on insurance identification card.
- Physician or other health care provider's contact information, including name, phone number, and address (address is optional).
- **Any "explanation of benefits" (EOB) you may have received from your insurance company or other medical documents related to the denial you are appealing.**

Please submit copies of any documents (see above in **BOLD)** you may want us to consider in making our decision. Once OPM accepts your request for external review, we will notify you. You will have twenty (20) days to submit any relevant information that you believe supports your claim. OPM will consider that information together with information we receive from your insurance company and other sources. We will base our decision on this complete record of information.

Authorized Representative:

- You may appoint a representative to handle all matters related to your request for External Review by completing the Authorized Representative Form. The form is available from the MSP website at http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review. The patient and the patient's authorized representative must together sign and submit a single Authorized Representative Form. If a legal representative other than the parent of a minor will complete the Authorized Representative Form on behalf of the patient, the legal representative must also provide proof of his or her legal representation (for example, a power of attorney instrument or proof of guardianship).

Patient Information

1. Are you the patient whose claim was denied, or are you the patient's authorized representative?

    ____ Patient

    ____ Authorized Representative. OPM will recognize an authorized representative if the patient and his or her authorized representative have completed and submitted the External Review Authorized Representative Form. The External Review Authorized Representative Form is available from the MSP website at http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review.

2. Patient Relationship to Primary Insured (pick one).

    ____ Self ____Spouse ____ Dependent child under age 26

3. Patient Name:

    Title: _____ First ________________ Middle____________ Last ________________________

    Suffix ________

4. Patient Date of Birth: Month: ____ Day: ____ Year: ____

5. Patient Contact Information:

    Street Address 1: ____

    Street Address 2: ____

    City: ____

    State: ___________________ Zip Code: ________________________________

    Email Address: ____

    Primary Phone: ____

    _______I grant OPM permission to leave voice mail at the primary phone number above.

    Secondary Phone: ____

    _______ I grant OPM permission to leave voice mail at the secondary phone number above.

    Select one: ____ I prefer to communicate with OPM by U.S. Mail.

    ____ I prefer to communicate with OPM by email.

Case Background Questions

1. Is this claim about health care you have already received, or is it about denial of requested pre-authorization?

_____Service Already Received

_____Pre-authorization Requested

2. Are you currently admitted to a hospital or treatment facility and will you be required to leave due to your denied claim?

___Yes ___No

3. Has your doctor or other health care provider determined that your life will be at risk if you do not receive this treatment in the next 30 days?

___Yes ___No

4. Has your doctor or other health care provider determined that, if you wait 30 days for care, you might never fully recover?

___Yes ___No

5. Have you filed an appeal with your insurance company?

___Yes ___No

If yes, date of appeal to insurance company: Month: ____ Day: ____ Year: ____

6. If you answered Yes to Question 5, have you received a letter from your insurance company denying your appeal?

___Yes ___No

If yes, date of appeal denial: Month: ____ Day: ____ Year: ____

Additional Details or Comments:

Health Care Provider Information

1. Health Care Provider or Facility Providing Treatment:

Facility Name: ______________________________

Health Care Provider Name: ______________________________

Title: ____ First ____________ Middle __________ Last ____________________

2. Health Care Provider or Facility Contact Information

Street Address 1: ______________________________

Street Address 2: ______________________________

City: ______________________________

State: ______________________ Zip Code: ______________________

Email Address: ______________________________

Office Phone: ____________________ Fax Number: ____________________

_______ I grant OPM permission to communicate with my provider by leaving a leave voice mail at the office phone number above and by mail and email.

Health Insurance Information

Please refer to your Health Insurance member ID card to complete the section below.

1. Patient's Health Insurance Member ID: ______________________________

3. Effective Date of Coverage: ______________________________

4. Patient's Coverage State: ______________________________

5. Insurance Company: ______________________________

6. Plan Name: ______________________________

7. Primary Insured Full Name: First ____________ Middle ____________ Last ______________

Claim Information

Please use any Explanation of Benefit (EOB) form, denial letters to help complete the section below.

1. Insurance Claim Number and/or Reference Number as listed on communication received from your insurance company: ____

2. Dates of Service: Month: ____ Day: ____ Year: ____; Month: ____ Day: ____ Year: ____

3. Date Pre-authorization was requested by health care provider, if any: Month: ____ Day: ____ Year: ____

4. Scheduled Dates of Service, if any, for which pre-authorization was sought:
Month: ____ Day: ____ Year: ____

5. Describe the basis for your External Review request:

____ I authorize OPM and its contracted Independent Review Organization to conduct medical review, and I release any appropriate medical records for use by OPM to conduct external review of my claim.

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 60 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 3206-0263 is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.