Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

<u>This document contains important information that you should retain for your records.</u>
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).

<u>Internal Appeal Case Details:</u>

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

[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*.

<u>[Insert language assistance disclosure here, if applicable.</u>
SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].
CHINESE ( ): □□□□□□□□□□□□□□□□□ [insert telephone number]□
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number]. **]**

Important Information about Your Rights to External Review

What if I need help understanding this denial? Contact us [insert contact information] 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? For certain types of claims, you are entitled to request an independent, external review of our decision. Contact [insert external review contact information] with any questions on your rights to external review. [For insured coverage, insert: If your claim is not eligible for independent external review but you still disagree with the denial, your state insurance regulator may be able to help to resolve the dispute.] See the "Other resources section" of this form for help filing a request for external review.

How do I file a request for external review? Complete the bottom of this page, make a copy, and send this document to {insert address}.] [or] [insert alternative instructions.] See also the "Other resources to help you" section of this form for assistance filing a request for external review.

What if my situation is urgent? If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by [insert instructions to begin the process (such as by phone, fax, electronic submission, etc.)].

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. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, once your external review is initiated, 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 us at [insert contact information].

What happens next? If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization 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: [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact:[insert contact information].]

NAME OF PERSON FILING REQUEST FOR EXTERNAL REVIEW: _________________________

Circle one:Covered person   Patient   Authorized Representative

Contact information of person filing request for external review (if different from patient)

Address:__________________Daytime phone:_________________Email:_______________

If person filing request for external review is other than patient, patient must indicate authorization by signing here:____

Are you requesting an urgent review? Yes   No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**

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Send this form and your denial notice to: [Insert name and contact information]

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.