

Model Notice of Final External Review Decision

OMB Control No.: 1210-0144
Expiration Date: 05/31/2025

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 external review decision. We have
[upheld/overturned/modified] the denial of your request for the provision of, or payment for, a
health care service or course of treatment.

Historical Case Details:

Patient Name:				ID Number:			
Address: (street, county, state, zip)							
Claim #:				Date of Service:			
Provider:							
Reason for 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, date appeal filed, date appeal was received by IRO and date IRO decision was made.*

Final External Review Decision: *State decision. List all documents and statements that were reviewed to make this final external review decision.*

Findings: *Discuss the principal reason or reasons for IRO decision, including the rationale and any evidence-based standards or coverage provisions that were relied on in making this decision.*

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[Insert language assistance disclosure here, if applicable.]

[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 (中文): 如果需要中文的帮助, 请拨打这个号码[insert

telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' [insert telephone number].]

[Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf [insert telephone number] uff.]

[Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni [insert telephone number].]

[Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye [insert telephone number].]

[Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang [insert telephone number].]

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **1210-0144 (Expires 05/31/2025)**. This document serves as notice of a final external review decision. The responses to this information collection are mandatory. The time required to complete this information collection is estimated to average between 30 minutes and 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this information collection, please write to: U.S. Department of Labor, Employee Benefits Security Administration, Office of Research and Analysis, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0144.

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Important Information about Your Appeal Rights

What if I need help understanding this decision?

Contact us [insert IRO contact information] if you need assistance understanding this notice.

What happens now? If we have overturned the denial, your plan or health insurance issuer will now provide service or payment.

If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

Other resources to help you: For questions about your appeal 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, you can contact your consumer assistance program at [insert contact information].]