MAXIMUS Federal Services

HHS-Administered Federal External Review Request Form

In most cases, you must complete the mandatory internal appeal offered by your health plan or insurance issuer before we can begin an external review. Additionally, we must receive this completed form within four months of the date your plan or insurer sent you a final decision denying your services or your claim for payment.

Medical Necessity Reviews

Any health plan or insurance issuer denials associated with medical necessity, appropriateness, health care setting, and level of care, effectiveness of a covered benefit, experimental/investigational treatment, and any other matters involving medical judgment.

Rescission Reviews

A decision by a health plan or health issuer to retroactively cancel (back to an earlier date) or discontinue a policyholder's coverage.

No Surprises Act Reviews:

Health plan or insurance issuer denials or decisions associated with claim processing and payment issues, such as: (1) patient cost sharing protections for emergency services; (2) patient cost sharing protections related to care provided by nonparticipating providers at participating facilities; (3) whether patients are in a condition to receive notice and provide informed consent to waive No Surprises Act protections; and (4) whether a claim for care received is coded correctly and accurately reflects the treatment(s) received, and any related patient cost-sharing

Section 1: Covered person

This section is about the person who received or will receive the benefit or treatment.

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Please complete this section if you are the covered person's parent or legal guardian

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Section 2: Insurance company information

Please complete this section for each insurance company involved with your claim.

Insurance company #1:	Insurance plan or plan option *(if applicable):*
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Insurance company #2:	Insurance plan or plan option *(if applicable):*
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Section 3: Dispute Description

Please describe the reason(s) for the dispute.

Have you already received these medical services? Yes No

If so, when were the services received? *(Month, day, year)* _____

Please state the reason that you believe the Health Plan's decision was not correct.

Section 4: Claims for Urgent Care

If you believe your situation is urgent, you may ask for an expedited (fast) review.

An urgent care situation is one in which your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision.

To ask for an expedited external review:

Fax this form to 1-888-866-6190 OR Mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 708, Pittsford, NY 14534.

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant's condition. The medical professional will not be required to submit proof of authorization.

If you have questions about your external review, call: **1-888-975-1080** or email ferp@maximus.com.

Is this external review for urgent care? ☐Yes ☐No

Section 5: Claims involving a rescission of coverage

A **rescission** is an action by a health insurance issuer to retroactively cancel (back to an earlier date) or discontinue a policyholder's coverage.

Is this request for external review of a rescission of health insurance coverage? ☐Yes ☐No

Section 6: Additional information you may give

MAXIMUS Federal Services will use the information on this form to get the relevant information and documents from your insurer. You may add supporting information and documents you think the insurer may not be able to provide.

For example, you may choose to give us:

- Documents to support the claim, such as physicians' letters, reports, bills, medical records, and Explanation of Benefits (EOB) forms
- Letters you sent to your insurance plan or issuer about the claim
- Letters the plan or issuer sent to you about the claim

You do not have to give us this additional information. However, if you do not give us any additional information, MAXIMUS Federal Services may decide your case based only on the information your insurance issuer or plan gives us.

You can give MAXIMUS additional information for your external review by sending it with this form:

Fax to 1-888-866-6190 **OR** mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 708, Pittsford, NY 14534.

If you have questions about your external review, call **1-888-975-1080**.

Questions?	Call **1-888-975-1080** Monday – Friday 8:00am – 5:00pm EST

Sign the consent form.

Please sign and date the form.

Signature:_____ Date: _____

Printed name: _____

I am the: ☐ Covered person ☐ Parent or legal guardian ☐ Authorized Representative

NOTE: The covered person must sign this consent form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form. If the covered person cannot sign this form, the authorized representative must give written proof of his or her authority to sign. You may obtain the Authorized Representative form at https://externalappeal.cms.gov/ferpportal/#/forms

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Privacy Act Statement: The following website provides a notice of your rights under the Privacy Act and includes information about how the information on this form will be used and about our legal authority to collect this information: http://cciio.cms.gov/resources/other/index.html.