BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Appeals and Disputes Department

EXTERNAL REVIEW REQUEST FORM

This External Review Form must be filed with Blue Cross and Blue Shield of Florida, Inc., (BCBSF) Member Appeals Department within four (4) months after receipt of your final adverse benefit determination regarding coverage of a health care service or treatment.

APPLICANT NAME _____

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____ Patient Name: _____

Address: _____

Covered Person Phone #: Home (_____) _____Work (_____) _____

INSURANCE INFORMATION

Insurer/Administrator/HMO Name: _____

Contract Number: _____ Telephone #: (_____) _____

Insurer/Administrator/HMO Mailing Address: PO Box 44197, Jacksonville, FL 32231-4197

EMPLOYER INFORMATION

Employer's Name: _____Employer's Phone #: (_____) _____

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address: _____

Phone: (____) _____ Contact Person: _____

Medical Record #:_____

REASON FOR HEALTH CARRIER DENIAL

Claim Number(s) (if applicable): _____

(Please check one)

☐ The health care service or treatment is not medically necessary.

☐ The health care service or treatment is experimental or investigational.

☐ Benefit Limitation/Exclusion ☐ Non-authorized services ☐ Out-of-Network services

☐ Financial (billing, reimbursement, etc.) ☐ Pre-Existing Condition

☐ Other Benefit Determination: _____

EXPEDITED REVIEW

If you need an urgent decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.
NOTE: Post Service Claims are Not Eligible for Expedited Review.
Is this request for an expedited appeal? Yes ☐ No ☐

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SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your claim denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize BCBSF and my health care providers to release all relevant medical or treatment records to the independent review organization. I understand that the independent review organization will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

_____ _____
Signature of Covered Person (or legal representative) Date
(Parent, Guardian, Conservator or Other – Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE
(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____
Signature of Covered Person (or legal representative) Date
(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative: _____

Phone #: Daytime (_____) _____Evening (_____) _____

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the disagreement with your health carrier. Indicate clearly the service(s) being denied and the specific date(s) being denied. Explain why you disagree. Attach additional pages if necessary and include available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies, and any additional information from your physician/health care provider that you want the independent review organization reviewer to consider.

WHAT TO SEND AND WHERE TO SEND IT (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL THREE ITEMS BELOW ARE INCLUDED)

1. ☐ **YES**, I have included this completed application form signed and dated.
2. ☐ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
3. ☐ **YES**, I have enclosed the letter from my health carrier or utilization review company that states:
   (a) Their decision is final and that I have exhausted all internal review procedures; or
   (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

Please call the Customer Service Department number on your BCBSF Member ID card, if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review. You can request an external review by faxing the forms to 904-565-6637 or mailing it to:

BlueCross and BlueShield of Florida
Attention: Appeals and Disputes Department
PO Box 44197
Jacksonville, FL 32231-4197

You can submit additional written comments to the external reviewer using the same contact methods above. If any additional information is submitted, it will be shared with the health insurance issuer in order to give the health insurance issuer an opportunity to reconsider the denial

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