



EXTERNAL REVIEW REQUEST FORM

Name of person filing request for external review:

Relationship to covered person: Covered Person/Applicant

Authorized Representative *(please complete the Appointment of Authorized Representative section)*

How would you like us to contact you? Phone Fax Email Mail

Contact information of authorized representative (if applicable)

Mailing Address:

Daytime Phone:

Evening Phone:

Email Address:

Fax:

Covered Person/Applicant Information

Name:

ID Number:

Mailing Address:

Daytime Phone:

Evening Phone:

Email Address:

Fax:

Treating Physician/Health Care Provider Information

Name:

Mailing Address:

Phone Number:

Email Address:

Fax Number:

Contact Person:

Phone Number:

External Review Specifications

1. If your situation is urgent, are you requesting an expedited review?* YES NO

2. Is your requested health care service considered an experimental or investigational treatment? ** YES NO

*If you answer yes, your physician must certify that your condition could, in the absence of immediate medical treatment, result in the following:

- Seriously jeopardize your life or health or your ability to regain maximum function, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim



EXTERNAL REVIEW REQUEST FORM

**If you answer yes, your physician must certify that he or she is requesting authorization for a drug, device, procedure or therapy denied for coverage due to the determination that the treatment is experimental and/or investigational and the your medical condition meets certain requirements:

- Standard health care services have not been effective in improving your condition
- Standard health care services are not medically appropriate for you
- There is no available standard health care service covered by the health plan issuer that is more beneficial than the requested health care service

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):

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may 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 external review on my behalf.

Signature of Covered Person (or legal representative**)

Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I _____ hereby request an external review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, health care provider and/or health plan issuer to release all relevant medical or treatment records to the independent review organization and/or the Ohio Department of Insurance. I understand that the independent review organization and the Ohio Department of Insurance will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

Signature of Covered Person (or legal representative**)

Date



EXTERNAL REVIEW REQUEST FORM

**Parent, Guardian, Conservator or Other - please specify*

SEND THIS FORM AND A COPY OF YOUR NOTICE OF FINAL ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING ADDRESSES:

Fax Number: 330-363-3066

Email Address: Appeals@aultcare.com

Mailing Address:

Attention: Grievance and Appeal Coordinator
P.O. Box 6029
Canton, Ohio 44706

Be certain to keep copies of this form, your Notice of Final Adverse Benefit Determination and all documents and correspondence related to this claim.



EXTERNAL REVIEW REQUEST FORM

AultCare/Aultra Notice Tag Lines for the State of Ohio

English

This Notice has Important Information. This notice has important information about your application or coverage through **AultCare/Aultra**. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. **Call Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 330.363.2393 Outside Stark County: 1.866.633.4752**

Spanish

Español

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través **AultCare/Aultra**. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al **Local : 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 330.363.2393 Fuera del condado de Stark : 1.866.633.4752**

Chinese

中文

本通知有重要的訊息。本通知有關於您透過**AultCare/Aultra**保險公司提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 本地： 330.363.6360 斯塔克縣外： 1.800.344.8858 TTY 本地： 330.363.2393 斯塔克縣外： 1.866.633.4752。

German

Deutsche

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch **AultCare/Aultra**. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752.**

Arabic

العربية

يحتوي هذا الشعار معلومات هامة. يحتوي هذا الشعار على معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال شركة التأمين AultCare/Aultra ابحث عن التواريخ الهامة في هذا الشعار. قد تحتاج اتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 330.363.6360 خارج مقاطعة ستارك: 1.800.344.8858 TTY المحلي: 330.363.2393 خارج مقاطعة ستارك: 1.866.633.4752

Pennsylvania Dutch

Deutsch

Die Bekanntmachung gebt wicdhichi Auskunft. Die Bekanntmachung gebt wicdhichi Auskunft baut dei Application oder Coverage mit **AultCare/Aultra**. Geb Acht fer wicdhiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimme Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752.**

Russian

русский

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через **Страховая компания AultCare/Aultra**. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 330.363.2393 Вне Старка County : 1.866.633.4752.**

French

Français

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de **Compagnie d'Assurance AultCare/Aultra**. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette



EXTERNAL REVIEW REQUEST FORM

information et de l'aide dans votre langue à aucun coût. **Appelez Locale: 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 330.363.2393 En dehors du comté de Stark : 1.866.633.4752**

Vietnamese

Việt Nam

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bản về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Công ty Bảo hiểm AultCare/Aultra. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 330.363.2393 Bên ngoài của Stark County : 1.866.633.4752.**

Cushite-Oromo

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa **AultCare/Aultra** tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bililaa haala

ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 330.363.2393 Outside of Stark County: 1.866.633.4752** tii bilbilaa.

Korean

한국어

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 **AultCare/Aultra 보험 회사계획**을 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. **지역 : 330.363.6360 스타크 카운티의 외부 : 1.800.344.8858 TTY 라인 지역 : 330.363.2393 스타크 카운티의 외부 : 1.866.633.4752** 로 전화하십시오.

Italian

Italiano

Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso **AultCare/Aultra**. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama **Locale: 330.363.6360 Al di fuori di Stark County : 1.800.344.8858 TTY linea Locale: 330.363.2393 Al di fuori di Stark County : 1.866.633.4752.**

Japanese

日本語

この通知には重要な情報が含まれています。この通知には**AultCare/Aultra保険会社**の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。 **330.363.6360 スターク郡の外 : 1.800.344.8858 TTYライン ローカル : 330.363.2393 スターク郡の外 : 1.866.633.4752**までお電話ください。

Dutch

Nederlands

Deze mededeling heeft belangrijke informatie. Deze mededeling heeft belangrijke informatie over uw aanvraag of dekking via **AultCare /Aultra**. Kijk naar belangrijke datums in deze mededeling. Het kan nodig zijn om actie te ondernemen binnen bepaalde termijnen om uw zorgverzekering te behouden of hulp met kosten te krijgen. U heeft het recht op deze informatie en hulp in uw taal zonder kosten. Bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 330.363.2393 Buiten Stark County : 1.866.633.4752.**

Ukrainian

український

Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страховального покриття через **Страхова компанія AultCare/Aultra**. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону **Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 330.363.2393 Поза Старка County : 1.866.633.4752.**

Romanian



EXTERNAL REVIEW REQUEST FORM

Română

Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin **Compania de Asigurari AultCare/Aultra**. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 330.363.2393 In afara Stark Judet : 1.866.633.4752.**

Non-Discrimination Notice:

AultCare/Aultra complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AultCare/Aultra does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AultCare/Aultra provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). AultCare/Aultra provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, or if you believe that AultCare/Aultra has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: AultCare/Aultra Civil Rights Coordinator, 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, CivilRightsCoordinator@aultcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.