

External review application

For most types of claims, you or your authorized representative may request an independent, external review of our decision by sending a completed application to Blue Shield of California at the address or fax number at the end of this form within four months from the date of our notification of final adverse benefit decision.

Additionally, if your situation meets the definition of urgent under the law, you or your authorized representative may request expedited external review processing. 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. Please complete the expedited processing section of the application and we will review your request for expedited processing.

Blue Shield will conduct a preliminary review of your application within five business days following the date of receipt and will determine if your claim is eligible for external review. Within one business day from our preliminary review determination, we will issue written notification regarding the status of your request.

We will submit eligible external review requests to an Independent Review Organization (IRO) and issue a written notice of the final external review decision within 45 days after submission. We will issue expedited external review decisions as soon as possible to accommodate the patient's condition, not to exceed 72 hours after submission.

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-EBSA (3272).

Mail completed applications to:

Blue Shield of California
Attn: External Review
P.O. Box 5588
El Dorado Hills, CA 95762

Fax completed applications to: (844) 696-6071

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|------------------------------------|--|
| Subscriber name: | Subscriber ID #: |
| Patient name: | Phone number: |
| Mailing address: | |
| Name of person submitting request: | |
| Relationship to patient: | <input type="checkbox"/> Self <input type="checkbox"/> Covered person <input type="checkbox"/> Authorized representative |
| Phone number: | |
| Mailing address: | |

If authorized representative checked, I authorize the above person to act on my behalf and authorize information pertaining to this external review to be released to the above person.

Signature

Date

Claim #(s):

Date(s) of service:

Briefly describe the disputed medical service or expense that you want reviewed and the specific outcome desired.

Expedited processing requested (reason for expedited processing required below)

I hereby request independent, external review of my dispute. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information for the purposes of independent external review. This authorizes release by and among all medical providers, Blue Shield of California, and any independent medical review organization. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a complaint regarding healthcare services. This authorization will expire one year from the date below, and it may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously released pursuant to this authorization. I understand I have a right to receive a copy of this authorization.

Signature

Date

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