Request for External Review

Blue Cross Blue Shield of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

You may be eligible for an External Review at no cost to you if ALL of the following apply:

- You have exhausted BCBSM's internal appeals process (unless waived because BCBSM did not complete its review within the required time).
- The request is within 4 months of receipt of a Final Adverse Determination.
- The patient was covered on the date of service.
- The health care service appears to be a covered benefit.
- And, where these requirements are met, the external reviewer determines the claim decision involves medical judgment, or that there was a rescission of coverage.

You are responsible for submitting:

- A copy of the Final Adverse Determination from BCBSM or its third party designee
- Pertinent documentation, such as bills, explanations of benefits, medical records, correspondence, statements from doctors, research material that supports your position, etc.

Note: It is your responsibility to submit medical records
Always send copies. Never send original documents.

1. Patient Name | Name of INSURED Person

BCBSM Policy (Contract) Number | Group Number | Claim number (if applicable)

Dates service was received or requested ➢ If service was received, enter date received. If not, enter date service was requested.

Name of physician and medical facility involved

2. Statement of request: Provide a brief explanation of the problem and the resolution you are seeking. Describe the medical service or requested service.

4. This request is being filed by (choose one)
□ The patient – provide patient's contact information in Part 5
□ The patient's parent (if patient is a minor child); or the patient's legal guardian – provide parent or legal guardian's contact information in Part 5
□ A representative authorized by the patient – provide authorized representative's contact information in Part 5

5. Contact information for person filling this form

Name of Patient, Parent, Legal Guardian or Authorize Representative

Address

City | State | Zip

Daytime phone number | Evening phone number

If you are not the patient, what is your relationship to the patient?

If person filling is NOT the patient or the patient's parent or the patient's legal guardian, the patient must designate the representative by reading and signing the statement in Part 6 below:

6. Patient authorization statement
I authorize the person named in Part 5 to act as my authorized representative in this External Review.

Signature of Patient | Date

7. Authorization to review medical information

I authorize the Independent Review Organization and any other health care provider needed to review protected health information and records pertaining to this external review.

Signature of Patient | Date

8. Send your Request for External Review to:

BCBSM External Review Requests
600 Lafayette East – Mail Code 1620
Detroit, MI 48226 – 2998
Fax: 877-522-4767

3. Urgent External Review Requirements (If you are not requesting an urgent external review, or your request does not meet the conditions below, skip to Part 4.)

The following conditions must be met:

- An urgent INTERNAL review has been requested AND
- The request is filed within 10 days of receipt of adverse determination AND
- A physician substantiates the medical condition involved in the adverse determination is serious enough to jeopardize the life or health of the covered person.

My request meets these requirements. By completing items (3a.) and (3b.), I am requesting an Urgent External Review.

(3a.) Date you requested an Urgent INTERNAL review _____

(3b.) Name and phone number of substantiating physician _____

Telephone number (Expedited External Review request only. Conditions in section 3 must be met.): 313-225-0646

Revised 09/09/20