You may be eligible for an External Review at no cost to you if ALL of the following apply:
- You obtained your plan from the Marketplace on Healthcare.gov.
- You made a request to receive a drug not covered under your plan and you were denied.
- Your request for external review is within 4 months of receipt of the denial.
- The patient is covered under the plan.

You are responsible for submitting:
- A copy of the denial of your exception request.
- Pertinent documentation, such as medical records, 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
2. Statement of request:
   a. Provide a brief explanation of the problem and the resolution you are seeking.
   b. Include a statement from your physician that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug or would have adverse effects.
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:
   - You’re going through a treatment that isn't listed on the pharmacy drug list.
   - Your health condition could be life threatening or you may lose the ability to regain full bodily function.
   - The timeframe of 72 hours would seriously jeopardize your life or health.
   - The request is filed within 10 days of receipt of the denial of your exception request.

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

   (3a.) Date you requested an urgent exception request ________________________
   (3b.) Name and phone number of substantiating physician ________________________

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

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 – Exception for Non-Covered Drug
   600 Lafayette East – Mail Code 1905
   Detroit, MI 48226 – 2998
   Fax: 866-422-5055