

Model Notice of Final External Review Decision – Revised June 22, 2011

## Date of Notice

**Name of Plan**

**Telephone/Fax**

**Address**

**Website/Email Address**

**This document contains important information that you should retain for your records.**

This document serves as notice of a final external review decision. We have **[upheld/overturned/modified]** the denial of your request for the provision of, or payment for, a health care service or course of treatment.

## Historical Case Details:

|   |                     |                        |                   |   |                    |                                |                  |
|---|---------------------|------------------------|-------------------|---|--------------------|--------------------------------|------------------|
| <b>Patient Name:</b>                            |                     |                        |                   | <b>ID Number:</b>                               |                    |                                |                  |
| <b>Address: (street, county, state, zip)</b>    |                     |                        |                   |   |                    |                                |                  |
| <b>Claim #:</b>                                 |                     |                        |                   | <b>Date of Service:</b>                         |                    |                                |                  |
| <b>Provider:</b>                                |                     |                        |                   |   |                    |                                |                  |
| <b>Reason for Denial (in whole or in part):</b> |                     |                        |                   |   |                    |                                |                  |
| <b>Amt. Charged</b>                             | <b>Allowed Amt.</b> | <b>Other Insurance</b> | <b>Deductible</b> | <b>Co-pay</b>                                   | <b>Coinsurance</b> | <b>Other Amts. Not Covered</b> | <b>Amt. Paid</b> |
| <b>YTD Credit toward Deductible:</b>            |                     |                        |                   | <b>YTD Credit toward Out-of-Pocket Maximum:</b> |                    |                                |                  |
| <b>Description of Service:</b>                  |                     |                        |                   | <b>Denial Codes:</b>                            |                    |                                |                  |

*[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]*

**Background Information:** *Describe facts of the case including type of appeal, date appeal filed, date appeal was received by IRO and date IRO decision was made.*

**Final External Review Decision:** *State decision. List all documents and statements that were reviewed to make this final external review decision.*

**Findings:** *Discuss the principal reason or reasons for IRO decision, including the rationale and any evidence-based standards or coverage provisions that were relied on in making this decision.*

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## Important Information about Your Appeal Rights

### **What if I need help understanding this decision?**

Contact us [insert IRO contact information] if you need assistance understanding this notice.

**What happens now?** If we have overturned the denial, your plan or health insurance issuer will now provide service or payment.

If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

**Other resources to help you:** For questions about your appeal rights, this notice, or for assistance, you can contact [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, you can contact your consumer assistance program at [insert contact information].]

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1099 (**Expires 4/30/2022**). The time required to complete this information collection is estimated to average 11 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail StopC4-26-05, Baltimore, Maryland 21244-1850.