



State Corporation Commission  
Bureau of Insurance – External Review  
P.O. Box 1157  
Richmond, VA 23218  
Phone: 1-877-310-6560 Fax: (804) 371-9915  
Email: externalreview@scc.virginia.gov

## EXTERNAL REVIEW REQUEST FORM

This External Review Request Form must be filed with the Virginia Bureau of Insurance within **120 DAYS** after receipt from your health carrier of a denial of payment on a claim or request for coverage of a health care service or treatment.

**Name of Applicant:** \_\_\_\_\_

Applicant is: (check one) ☐ Covered person/Patient ☐ Provider ☐ Authorized Representative  
(NOTE: Form 216-B must be completed if the applicant is not the covered person.)

### Covered Person Information:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

### Insurance Information:

Health Carrier Name: \_\_\_\_\_

Covered Person Insurance ID#: \_\_\_\_\_

Insurance Claim/Reference #: \_\_\_\_\_

Health Carrier Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Carrier Phone: \_\_\_\_\_

**Employer Information:**

Employer's Name: \_\_\_\_\_

Employer's Phone:(\_\_\_\_\_) \_\_\_\_\_

Is the health coverage you have through your employer a self-funded plan? \_\_\_\_\_.  
(If you are not certain please check with your Human Resource office or plan administrator.)

**Health Care Provider Information:**

Treating Health Care Provider (for the denied services): \_\_\_\_\_

Address:

---

---

---

Contact Person: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

**Reason for Health Carrier Denial** (Please check one):

- ☐ The health care service or treatment does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.
- ☐ The health care service or treatment is experimental or investigational (Form 216-D is required).

(NOTE: Other reasons for denial are not eligible for external review.)

**SUMMARY OF EXTERNAL REVIEW REQUEST** (Enter a brief description of the health care service or treatment that was denied, and **attach a copy of the denial letter from your health carrier**).

---

---

---

**Do not attach medical records at this time.** If your appeal is determined to be eligible, you will be notified when and where to submit your medical records and other documentation in support of your appeal.

### EXPEDITED REVIEW

**If you need a fast decision**, you may request that your external review be handled on an expedited basis. You may not request an expedited review if the service has already been provided.

Has the service been provided? Yes \_\_\_\_\_ No \_\_\_\_\_

To complete this request, your treating health care provider **must** complete Form 216-C stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.\*

Is this a request for an expedited review? Yes \_\_\_\_\_ No \_\_\_\_\_

\*If you have received a final adverse determination involving emergency services, and you have not yet been discharged from a facility, check here \_\_\_\_\_. Form 216-C is not required.

### SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, \_\_\_\_\_, hereby request an external review. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize the health carrier, any third-party administrator, and the health care providers to release all relevant medical or treatment records to the independent review organization. I understand that the independent review organization will use this information to make a determination on this external review and that the information will be kept confidential and not be released to anyone else. This release is valid until the external review is complete.

\_\_\_\_\_  
Signature of Covered Person (or legal representative\*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Parent, Guardian, Conservator or Other – please specify