



**New Jersey Department of Banking and Insurance
The Independent Health Care Appeals Program**

EXTERNAL APPEAL APPLICATION

Return Application by mail to:

E-mail application to:

New Jersey Department of Banking and Insurance
Office of Managed Care
P.O. Box 472
Trenton, NJ 08625-0329
(If using courier service: 20 West State Street, 9th Floor)

ihcap@dobi.nj.gov

Call **1-888-393-1062** or **(609) 777-9470** for help completing the application.

Section I. INFORMATION ON COVERED PERSON (Person who was denied the Services)

First and Last Name:

Birthdate:

Address (Street, Apt or Suite #, City, State, Zip Code):

Daytime telephone:

E-mail address:

Section II. INSURANCE INFORMATION FOR COVERED PERSON

Insurance Company or HMO:

ID Number

Policy Number:

Note: Do not send Medicare appeals or appeals involving Self-Funded Plans. You must be covered by a fully insured plan issued in New Jersey or covered by NJ Family Care (Medicaid) to file this appeal. Please call us if you have a question about your coverage.

Coverage is ☐ Individual Coverage

☐ Employer Name of employer _____

☐ NJ FamilyCare

Section III. TO BE COMPLETED BY PERSON FILING THE APPEAL

Name of person filing the appeal: _____

Relationship to the covered person: ☐ Self ☐ Relative ☐ Provider ☐ Advocate

If you are a relative, provider or advocate, please provide your contact information.

Daytime telephone: _____ E-mail address: _____

Address: _____

Contact Person if the appeal is filed by a Provider: _____

Medical Record #: _____

Section IV. SIGNATURE

A. Sign this section if you are filing the appeal yourself or are a relative.

CONSENT FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

I understand that a copy of this form and any enclosures may be sent to the Independent Utilization Review Organization (IURO) and the Carrier named in the appeal. I authorize the release of any medical and/or administrative records pertinent to this appeal to the IURO selected by the New Jersey Department of Banking and Insurance.

Signature of Covered Person (Covered person must be 18 years or older) *Date*

Signature of Parent or Relative *Relationship* *Date*

B. Sign this section if you are a provider or advocate filing the appeal on behalf of the covered person

CONSENT FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

I am filing as a provider or advocate, acting on behalf of a covered person with the covered person's consent. To my knowledge and belief, I am authorized to file this application for appeal and to release any pertinent medical and/or administrative records to the IURO.

Signature of Provider or Advocate *Date*

Is a signed Consent form included with the application? ☐ YES ☐ *NO

** The appeal cannot be processed until the consent form is received by the Department. A copy of the consent form is included with this application.*

V. SUMMARY OF APPEAL

Describe the services denied by your carrier and the reason you believe the carrier's decision was not correct. Attach a copy of the final written denial, if available.

Do not send medical records or original documents with this appeal.

EXTERNAL APPEAL APPLICATION INSTRUCTIONS

Has your health plan denied your request for covered medical services or treatment ?
You may be eligible to use the Independent Health Care Appeals Process (IHCAP) administered by the New Jersey Department of Banking and Insurance.

You can apply for an External Appeal through the IHCAP if you meet the following criteria:

- Your Health Plan denied, limited, or delayed a covered treatment, prescription, or service because the Health Plan determines it is not medically necessary or is experimental or investigational.
- You completed your Health Plan's internal appeal process or could not complete the internal appeal process for one of the following reasons:
 - Your Health Plan waived the internal appeal;
 - Your Health Plan did not comply with the internal appeal requirements; or
 - You are requesting an expedited internal appeal and an external appeal at the same time.
- Your health insurance coverage is through a fully-insured plan issued in New Jersey or NJ FamilyCare/Medicaid . If you are uncertain about your coverage, please look at the member ID card to confirm that it clearly states "Fully-Insured." The Department will return the application if you are covered by Medicare or by Self-funded plans or by insured plans issued outside of New Jersey

How to apply for an External Appeal:

1. Complete the External Appeal Application. You can give permission to another person to file the appeal for you. If this person is a health care provider or an advocate, he or she should include a signed and dated Consent to Representation in Appeals of Utilization Management Determinations and Authorizations for Release of Medical Records in UM Appeals and Independent Arbitration of Claims with the external appeal.
2. Sign and date the form.
3. Include a copy of the final written decision from the carrier, if available.
4. Include the \$25.00 filing fee in the form of a check or money order made payable to "New Jersey Department of Banking and Insurance. Do not send cash.
This fee is waived if you submit evidence of participation in one of the following: Pharmaceutical Assistance to the Aged and Disabled (PAAD), Medicaid NJ Family Care, General Assistance, SSI, or New Jersey Unemployment Assistance. .
5. Submit the application to the Department by mail or by e-mail. Expedited appeals can be faxed to the Department at (609) 633-0807
6. **Do not send medical records to the Department.** If the appeal is accepted for review by the IURO, you will receive a letter from the IURO with instructions on submitting medical records. .

For help completing the application, please call us. Our toll free number is
1-888-393-1062 or call **(609) 777-9470**.

See www.state.nj.us/dobi/division_insurance/managedcare/umappeal.htm for a full explanation of the carrier's internal utilization management appeal process and the external appeal process.



New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, , by marking ☒ (or ☐) and signing below, agree to:

- ☐ representation by in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.
- ☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID# _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of this document AFTER it has been completed, signed and dated.



New Jersey Department of Banking and Insurance

**NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF
UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO
RELEASE OF MEDICAL RECORDS**

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329

OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

**REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN
UM DETERMINATION APPEALS**

☐ I hereby revoke my consent to representation by _____ and
my authorization to the release of medical information in an appeal of an adverse UM determination. I
understand that by revoking consent, the UM appeal may not be pursued further by my health care
provider. I understand that this revocation may occur after my personal and medical information has
already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract,
but that no further distribution of records in this matter will occur based on my authorization, and that all of
my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID# _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME:		
Address (Street, Apt or Suite #, City, State, Zip Code):		
Telephone:	FAX:	E-mail address:

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy this document.