

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
HEALTH CLAIMS BUREAU
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov
CSD-003-IMR
Eff: 01/07/2019

Ricardo Lara, *Insurance Commissioner*



APPLICATION FOR INDEPENDENT MEDICAL REVIEW

If you wish to give authority to someone to assist you in filing this *Independent Medical Review (IMR)*, please complete the *Authorization for Release of Medical Records and Designation of Independent Medical Review Agent* form.

Patient's Name:		
Patient's Parent/Guardian, if filing for Minor Child:		
Patient's Date of Birth:	Patient's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		
Email:	Daytime Phone: ()	Alternate Phone: ()

The following information is used for statistics only. Providing this information is optional and will not affect the independent medical review process in any way.

Primary language spoken at home:
In order to ensure all Californians have access to health insurance, please identify your race/ethnicity:

Complete name of insurance company involved:	
Policy/Certificate number:	Claim number:
Date(s) of Medical Services Provided (if applicable):	
Did your insurance company say the treatment you want is (check one): <input type="checkbox"/> Not Medically Necessary <input type="checkbox"/> Experimental or Investigational <input type="checkbox"/> Other	
If there is an imminent and serious threat to the health of the insured or claimant, please check and indicate the diagnosis: <input type="checkbox"/> Diagnosis: _____	
Briefly describe the disputed medical service or expense that you want referred to the Independent Medical Review Organization and list the physicians who have treated you for this condition. Use additional paper as needed.	

I hereby request Independent Medical Review of my dispute with the insurer. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the insurer, the California Department of Insurance and any Independent Medical Review Organization. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously release pursuant to this authorization. I attest that the information provided is accurate and truthful.

Please provide any supporting documentation you may have related to this matter.

- ☐ Copy of insured's insurance identification card – both sides
☐ Copies of correspondence between you and the insurance company including all related Explanation of Benefits (EOBs)

Please be aware that a copy of your Application for Independent Medical Review and your supporting documentation will be provided to the insurance company and the Independent Medical Review Organization.

Patient (or Parent/Guardian if Minor Child) Signature _____ Date _____

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Eff: 06/01/2014

Ricardo Lara, Insurance Commissioner



INFORMATION AND INSTRUCTIONS REGARDING YOUR APPLICATION FOR INDEPENDENT MEDICAL REVIEW

Before you request an Independent Medical Review with the Department of Insurance, you are required to first file an appeal/grievance with the insurance company in an effort to resolve the issue(s). If you do not receive a satisfactory response after 30 days, then complete the application form, attach copies of any important papers that relate to your complaint and mail to the address shown on the application form. You may also attach additional sheets as necessary to explain and/or describe the situation and disagreement with your insurance company. We consider this information necessary to our review and within the powers and duties expressed in the California Insurance Code, Section 12921.3 and Section 10169. Please review our privacy statement regarding information we obtain from you.

You have the right to provide information or documentation you believe will support your position in this review.

You may inspect the information you submit at any time as long as the department's case is maintained. All original documents will be returned to you upon completion of our handling.

APPLICATION FOR INDEPENDENT MEDICAL REVIEW MAY BE SUBMITTED TO THE DEPARTMENT OF INSURANCE FOR THE FOLLOWING TYPES OF PROBLEMS:

1. Denial of a claim due to the company's opinion that the treatment or service is not medically necessary or that it is experimental and excluded by a policy provision.
2. An offer of an amount less than that indicated in the policy due to the company's opinion of medical necessity.
3. Delay in settlement of a claim due to the disputed issue of medical necessity.
4. Denial of a claim for urgent or emergency services.

Under the Independent Medical Review process, one or more physicians will determine these issues and their decision will be binding on the insurance company.

Please be aware that a copy of this Application for Independent Medical Review will be provided to the insurance company. Also, please be advised that:

- A decision not to participate in the independent review process may cause the forfeiture of any statutory right to pursue legal action against the insurer regarding the disputed health care service.
- Your consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any out-of-plan provider the insured may have consulted on the matter, is necessary to be signed by you.
- You have the right to provide information or documentation, either directly or through your provider, regarding any of the following:
 - The provider's recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.
 - Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.
 - Reasonable information supporting your position that the disputed health care service is or was medically necessary for the medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

**STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
AND DESIGNATION OF INDEPENDENT MEDICAL REVIEW AGENT**

In accordance with California Insurance Code section 10169(e), an insured may designate an agent to act on his or her behalf to assist that insured with the Independent Medical Review (IMR) process. If you want to give another person the authority to assist you with your Independent Medical Review (IMR), complete Parts A and B below.

Unless you wish to designate another person to assist you with the IMR process, if you are a parent or legal guardian filing this IMR for a child under the age of 18, you do not need to complete this form, but you must complete the Application for Independent Medical Review (IMR).

If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also, attach a copy of the power of attorney for the health care decisions or other documents that say you can make decisions for the patient.

PART A: Patient/Insured:

I allow the person named below in Part B to assist me in my IMR filed with the California Department of Insurance (CDI). I allow the CDI and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information. I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law.

Name of Patient (Print): _____

Signature of Patient or Insured: _____ Date: _____

PART B: Person Assisting Patient with IMR

Name of Person Assisting (print) _____

Signature of Person Assisting _____

Address _____

Relationship to Patient _____

Daytime Phone # _____

Evening Phone # _____

Email Address (if available): _____

☐ My power of attorney for health care decisions or other legal documents is attached.



Privacy Notice on Information Collection

Request for Assistance Forms

*** This notice is provided pursuant to the Information Practices Act of 1977 (California Civil Code Section 1798.17) ***

Collection and Use of Personal Information

California Insurance Code Sections 12921 and 12921.1, and related statutes and regulations, give the California Department of Insurance (CDI) and the Consumer Services Division the authority to regulate and investigate consumer complaints. The CDI uses your information to address complaints brought to the Department's attention. Information is collected subject to limitations contained in the Information Practices Act of 1977, SAM 5300, et seq., SIMM 5305, et seq., and other applicable state and federal laws.

Providing Personal Information Is Voluntary

You do not have to provide the personal information requested. However, if you do not wish to provide us the necessary information, we may not be able to investigate your complaint. When providing information or documents, please do not include unrequested personal information, such as Social Security Numbers, Driver's License Numbers, unnecessary health-related information, and credit card or financial information.

Information Provided to CDI Is Confidential

All information you provide to us during the investigation of your complaint will be treated as a confidential communication under California Insurance Code Section 12919. We will not disclose any information to any person outside CDI, unless otherwise permitted or required by law.

Possible Disclosure of Personal Information

We may share your personal information with the insurance licensee and in the case of an Independent Medical Review with the Independent Medical Review Organization. We may also share your information with other government agencies as required by law.

Access to Your Information

You have the right to access records containing your personal information which are maintained by CDI. To request access, contact: CDI Privacy Officer, Legal Division, Government Law Bureau, 300 Capitol Mall, Suite 1700, Sacramento, CA 95814, (916) 492-3500.

Department Privacy Policy

The California Department of Insurance has developed policies regarding the privacy of your information. They may be viewed at www.insurance.ca.gov/privacy-policy.

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
DOI / IMR

(To Be Completed By Treating Physician)

I hereby certify that I am the treating physician for _____ (insured's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is Experimental and/or Investigational. I understand that in order for the Insured to obtain the right to an Independent Medical Review of this denial, as treating physician I must certify that the Insured's medical condition meets certain requirements.

In my medical opinion as the Insured's treating physician, I hereby certify to the following:

(Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the member to qualify for an Independent Medical Review).

- ☐ 1) The Insured has a terminal medical condition, or a life threatening condition, or a seriously debilitating condition.
- ☐ 2) The Insured has a condition that qualifies under one or more of the following:
[please indicate which description(s) apply]:
- ☐ Standard therapies have not been effective in improving the Insured's condition;
- ☐ Standard therapies would not be medically appropriate for the Insured; or
- ☐ There is no more beneficial standard therapy covered by the policy.
- ☐ 3) The treatment I have recommended and which has been denied in my medical opinion, based on current clinical literature and medical evidence, is likely to be more beneficial to the Insured than any available standard therapies.
- ☐ 4) The treatment I have recommended would be significantly less effective if not promptly initiated.
Explain: _____

Contracted Providers: 1) Please state the evidence relied upon in this determination. Please provide a description below or attach to this request form, and fax to the Department.

2) Please provide a description of the experimental or investigational drug, device, procedure, or other therapy recommended by the patient or myself. (Attach additional sheets as necessary.)

Non-Contracted Providers or Insureds requesting Independent Medical Review on their own:

You are required to present two documents to the Department of Insurance from specialized medical and scientific literature sources to support the above certification that the requested therapy is likely to be more beneficial to the Enrollee than any available standard therapy. Please refer to the reverse side that lists the medical and scientific literature sources, which qualify as supporting documentation for Independent Medical Review requests, and fax or overnight.

Documentation may be forwarded by facsimile or overnighted with this form to:
Department of Insurance, IMR Unit, 300 South Spring Street, Los Angeles, CA 90013.
If you have any questions, the Department can be reached at (800) 927-4357, fax (213) 897-9641,
or the Department's web site at www.insurance.ca.gov.

Physician's/Insured's Signature

Date

STATE OF CALIFORNIA
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**MEDICAL and SCIENTIFIC EVIDENCE WHICH QUALIFIES
FOR INDEPENDENT MEDICAL REVIEW REQUESTS
as DEFINED UNDER HEALTH and SAFETY CODE SECTION 1370.4(d)**

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not a part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
5. Findings, studies and research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.