NEW YORK STATE EXTERNAL APPEAL APPLICATION

New York State Department of Financial Services, PO Box 7209, Albany NY, 12224-0209

If an HMO or insurer (health plan) denies health care services as not medically necessary, experimental / investigational (including a clinical trial or rare disease treatment) or out-of-network, complete and send this application to the above address within 4 months of the plan's final adverse determination if you are the patient or the patient's designee, or within 45 days if you are a provider appealing on your own behalf. For help call 1-800-400-8882 or e-mail externalappealquestions@dfs.ny.gov.

TO BE COMPLETED BY ALL APPLICANTS

1. **Applicant Name:** _____
   (Please check one.) [ ]Insured/Patient [ ]Patient's Designee [ ]Provider
2. **Patient Name:** _____
3. **Patient Address:** _____
   _____
4. **Patient Phone Number:** Home(_____)_____Work(_____)_____
5. **Patient E-mail (if patient submits application and wants contact by e-mail):** _____
6. **Name of the Patient's Health Plan:** _____
7. **Name of the Patient's Physician:** _____
8. **Physician Address:** _____
9. **Physician Phone Number:** (_____)_____ **Physician Fax Number:** (_____)_____
10. If the patient is covered under a Medicaid Managed Care Plan, has the patient requested a fair hearing through Medicaid or received a fair hearing determination? (Please check one.) [ ]Yes [ ]No [ ]Don't know
11. **Reason for Health Plan Denial:** (Please check one.)
    [ ] Not medically necessary [ ] Experimental / investigational (other)
    [ ] Experimental / investigational (clinical trial) [ ] Experimental / investigational (rare disease)
    [ ] Out-of-network and the health plan proposed an alternate in-network service
12. Describe the service and the date(s) of service and attach all information you want considered. _____

_____

13. **External Appeal Eligibility:** (Please check one.)
    [ ] Attached is the final adverse determination from the first level of appeal with the health plan.
    [ ] Attached is the health plan's letter waiving an internal appeal.
    [ ] The patient requested an expedited internal appeal at the same time as this external appeal.
    [ ] The health plan did not comply with internal appeal requirements for the patient's appeal.
14. **If the patient has not received the service, this appeal may be expedited.** An expedited decision will be made within 72 hours instead of 30 days, even if the patient or the patient's physician does not provide needed medical information to the external appeal agent. If this is a request for an expedited appeal check one of the following:
    [ ] The denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.
    [ ] The 30 day timeframe will seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health, and the patient's physician will complete the attached Physician Attestation (pages 4-6) and send it to the Department of Financial Services.
15. If this is an appeal of **experimental / investigational services (including a clinical trial or rare disease treatment)** or an **out-of-network denial,** the patient's physician who prescribed the treatment must complete the Physician Attestation (pages 4-6) and send it to the Department of Financial Services. See special rules for rare

diseases on page 6. (Please check one.) [ ] I gave the form to my physician. [ ] I did not give the form to my physician.

16. **External Appeal Fee:** You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you. (Please check one.)
[ ] I enclosed a check or money order made out to the health plan.
[ ] I faxed my application and will mail the fee to the Department of Financial Services within 3 days.
[ ] The patient is covered under Medicaid, Child Health Plus or Family Health Plus and no fee is charged.
[ ] The patient requests a fee waiver for hardship and the patient will provide documentation to the health plan.
[ ] The health plan does not charge a fee for an external appeal or the fee is not required.

17. **I am sending this application to the Department of Financial Services by:** (Please check one.)
[ ] Certified or registered mail to New York State External Appeal, PO Box 7209, Albany, NY 12224-0209.
[ ] Fax to **1-800-332-2729.** If your appeal is expedited, you must also call toll free 1-888-990-3991 to tell us.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for NYS External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

TO BE COMPLETED IF APPLICANT IS THE PATIENT'S DESIGNEE

18. **Complete this only if a designee submits this external appeal on the patient's behalf.** The patient may be asked to confirm that a designee was authorized.

Name of Designee: _____

Relationship to Patient: _____

Address: _____

Phone Number: (_____)_____ **Fax Number:** (_____)_____

Designee E-mail (if designee wants contact by e-mail): _____

TO BE COMPLETED IF APPLICANT IS THE PATIENT'S PROVIDER

19. Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. **This item should be completed by providers appealing on their own behalf, or appealing as the patient's designee.** The health plan's **initial denial** and **final adverse determination** from the first level of appeal must be attached.

I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a co-payment or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

Provider Name: _____

Person or Firm Representing Provider (if applicable): _____

Contact Person for Correspondence: _____

Address for Correspondence: _____

Phone Number: (_____)_____ **Fax Number:** (_____)_____

E-mail (if you want contact by e-mail): _____

Provider Signature:_____

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NYS EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans. In the event an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

_____

Signature of Patient **(Date)**

(Or the patient's representative who can consent to the release of the patient's medical records. If a parent signs for a minor child, indicate the age of the child. If a guardian or executor signs, include proof of the appointment.)

Print Name: _____

Patient's Health Plan ID#:_____

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

New York State Department of Financial Services, PO Box 7209, Albany NY, 12224-0209

The patient's **physician** must complete this attestation for any external appeal of a health plan's denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal.

- For an **experimental / investigational** denial (other than a clinical trial or rare disease treatment) the patient's physician must complete items **1-10 and 14**.
- For a **clinical trial** denial, the patient's physician must complete items **1-9, 11 and 14**.
- For an **out-of-network** denial, the patient's physician must complete items **1-9, 10 and 14**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 12 and 14**.
- For an **expedited appeal**, the patient's physician must complete items **1-9, 13 and 14**.

You must mail this attestation to the above address or fax it to 1-800-332-2729. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately. If you have any questions call 1-800-400-8882 or e-mail externalappealquestions@dfs.ny.gov.

1. **Name of Physician completing this form:** _____

To appeal an experimental / investigational, clinical trial, or out-of-network denial, the physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the patient, who recommended the patient's treatment. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.

2. **Physician Address:** _____

_____

3. **Contact Person:** _____

4. **Phone Number:** (_____)_____ **Fax Number:** (_____)_____

5. **Physician E-mail (if you want contact by e-mail):** _____

6. **Name of Patient:** _____

7. **Patient Address:** _____

8. **Patient Phone Number:** _____

9. **Patient Health Plan Name and ID Number:** _____

10. **Complete this item for an external appeal of an experimental / investigational denial or an out-of-network denial. DO NOT complete this item for an appeal of a patient's clinical trial participation or rare disease.**

For an experimental / investigational denial: As the patient's physician I attest: (Select a or b without altering.)

a. ___ Standard health services or procedures have been ineffective or would be medically inappropriate.

OR

b. ___ There does not exist a more beneficial standard health service or procedure covered by the health plan.

AND that I recommended a health service or pharmaceutical product that, based on the following **two** documents of medical and scientific evidence, is likely to be more beneficial to the patient than any covered standard health service. **(Complete c and d below.)**

For an out-of-network denial: As the patient's physician I attest that the out-of-network health service (identify service)

_____

_____

_____

is materially different from the alternate in-network health service recommended by the health plan, and based on the following **two** documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service. **(Complete c and d below.)**

c. List the documents relied upon in the space below **and attach a copy of the documents.**

Document #1 Title:_____

Publication Name: _____

Issue Number : _____ Date: _____

Document #2 Title: _____

Publication Name: _____

Issue Number :_____ Date: _____

d. The medical and scientific evidence listed above meets one of the following criteria. *(Note peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.)* **(Check the applicable items below for each of the documents.)**

[ ] Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, 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 Medicus, Medline and MEDLARS database Health Services Technology Assessment Research; Document #1 [ ] Document #2 [ ]

[ ] 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 part of the editorial staff; Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed abstracts accepted for presentation at major medical association meetings; Document #1 [ ] Document #2 [ ]

[ ] Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act; Document #1 [ ] Document #2 [ ]

[ ] The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the National Comprehensive Cancer Network's Drugs and Biological Compendium; (iii) the American Dental Association Accepted Dental Therapeutics; (iv) Thomson Micromedex DrugDex; or (v) Elsevier Gold Standard's Clinical Pharmacology; or other compendia as identified by the Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal; Document #1 [ ] Document #2 [ ]

[ ] Findings, studies, or 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. Document #1 [ ] Document #2 [ ]

11. **Complete this item only for a denial of a patient's participation in a clinical trial.**

a. ___ There exists a clinical trial which is open, the patient is eligible to participate, and the patient has or will likely be accepted. **(Although not required, it is recommended you enclose the clinical trial protocols and related information.)**

The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the

federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

12. **Complete this item only for a rare disease treatment denial.**

As a physician, other than the patient's treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service. I **do**____ **do not**____ **(check one)** have a material financial or professional relationship with the provider of the service **AND** (select a or b without altering):

a. ___ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.

OR

b.___ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

* If provision of the service requires approval of an Institutional Review Board include the approval with this attestation.

13. **Complete this item only for an expedited appeal.**

If the patient has **not yet received the treatment,** and **the 30 day timeframe will seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health,** the patient's physician may request the appeal to be expedited.

The external appeal agent must make an expedited decision within 72 hours, instead of 30 days, regardless of whether you provide all necessary medical information or records to the agent. **You must send any information to the agent immediately in order for it to be considered. (Please check one.)**

___**YES**, this appeal must be expedited. I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.

During non-business days I can be reached at:_____

___**NO**, this appeal does not need to be expedited.

14. **Complete this item for an external appeal of a health plan's denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal.**

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Physician Name (Please Print Clearly): _____

_____

Signature of Physician **(Date)**