
Health insurance external review appeal

If you have a health insurance claim that continues to be denied by a health plan company, you have the right to appeal that denial. Minnesota law requires your insurer to notify you of your right to an external appeal review by the Minnesota Department of Commerce.

Please see: § 62Q.73 for Individual & Group Health Plans; § 62M.06 for Stand-Alone Dental, Vision, or Hearing Plans

External Appeal

This External Review will be performed by a state approved contract vendor. Its employees and physicians are impartial, separate from, and have no affiliation with any health plan.

The result of an External Review is nonbinding on you, the insured, but it is binding on the health plan company. If your denial is upheld, you have the right to appeal the decision in court. If the health plan company denial is overturned, it cannot appeal the decision.

If you wish to file an appeal for an external review, please complete the attached application. We will forward your application to a state approved contract vendor.

Mediation Option (not available for expedited cases):

Most appeals are based on written information submitted by you and the health plan company. In mediation, however, you and the health plan company talk about the appeal and try to resolve it (by phone or in person) with a trained mediator. If both you and the health plan company request mediation, a state approved contract vendor decides if mediation is appropriate for your case.

All applications should be sent to:

External Review Process
Minnesota Department of Commerce
85 7th Place East, Ste. 280
St. Paul, MN 55101

If you have questions or need assistance:

Call the Consumer Services Center
651-539-1600 | 1-800-657-3602 (Greater MN)
Select the Insurance option (option #3) to speak with an insurance analyst who can assist you.

External Review Checklist

Items marked with an asterisk (*) are required. It is strongly recommended to include supporting documents but not required.

- * Completed External Review Application – signed and dated
- * Last denial letter from Insurer - must be dated within 6 months of date of appeal filing
- * Patient Summary of Appeal
 - Supporting documents, including but not limited to the following:
 - Medical records Studies or Research Imaging (MRI, X-ray, CT, etc.)
 - Statement from physician or provider

Application for External Review Appeal

Enrollee/Insured Information

Type of plan (select one): Health Dental Vision Hearing
Insurance Company Name: _____ Policy number: _____
Service, Treatment, or Medication which is being denied:
CPT code(s) (if applicable): _____

Enrollee/Insured Information

Enrollee/Insured Name:	Phone Number:
Dependent Name (if applicable):	Alternate Phone Number:
Enrollee/Insured Address:	Email Address:
City: _____ State: _____ Zip: _____	

Enrollee/Insured Representative Information

You have the right to choose a person to represent you in your appeal. The following section must be completed and signed by the enrollee/insured to appoint a representative.

Representative Name:	Phone Number:
Organization Name:	Relationship to Enrollee/Insured:
Address:	Email Address:
City: _____ State: _____ Zip: _____	Fax Number:

I am the enrollee/insured identified above and I authorize the person designated above to represent me in my external appeal.

Enrollee/Insured Signature: _____ Date: _____

Utilization Review Company Information

This is the company retained by your insurance company who denied your claim. If you do not know this information, please leave blank.

Company name: _____ Contact Person Phone: _____
Company Address: _____

Summary of Appeal

Please write a brief description of the claim or the request for treatment or service that was denied, why you are appealing this denial, what did/didn't work, how it affects you/patient, etc. If you need more space, feel free to submit an attachment or additional pages.

Expedited 72-Hour Reviews

Normal appeals can take up to 45 days to completed. Expedited reviews may be requested when a delay in review could seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function. This type of appeal is not required by law. The Department of Commerce encourages, but cannot require, your insurance company to participate.

Expedited reviews **must** provide the information noted on the External Review checklist (see page 1) and a statement from the physician or provider describing the reason for the expedited request.

This may be faxed to 651-539-0105 or e-mailed to consumer.protection@state.mn.us

- I am applying for an expedited review.
- I have included a statement from my physician or provider to support the expedite request (required)

Information on Use of Data

The information you are providing is needed to process your request for external review, and to forward the information to a state approved contract vendor. You are not legally required to provide any private or confidential data to an approved vendor or the Department of Commerce and you may refuse to provide any data. However, failure to provide requested data could affect the decision of your appeal. If the Department of Commerce identifies the need to conduct its own investigation of your complaint, we will contact you directly to discuss our investigation process and obtain any necessary information.

Signature and Release of Person Requesting Appeal

I certify that all of the information on this form is true to the best of my knowledge. I am insured in the above health plan company and that I have gone through my health plan company's internal appeal process. I authorize my health plan company and my medical providers to release my medical records to CHDR solely for the purpose of reviewing my appeal. This consent will be revoked upon the conclusion of the external review and appeal. I authorize the Department of Commerce to forward any documents connected to my external review appeal to a state approved contract vendor.

I am the enrollee/insured identified above and I agree to the terms outlined above.

Enrollee/Insured Signature: _____ Date: _____

Submission Information

Emailed submissions reduce the amount of time it takes for the Department to process your review.

Email Submission (Preferred)

Consumer.protection@state.mn.us

Subject line: Attn: External Review (Last Name)

Faxed Submission

651-539-0105

Attn: External Review (Last Name)

Mailed Submission:

External Review Process

Minnesota Department of Commerce

85 7th Place East, Ste. 280

St. Paul, MN 55101

If you have questions or need assistance:

651-539-1600 | 1-800-657-3602 (Greater MN)

Select the Insurance option (option #3) to speak with an insurance analyst who can assist you.