REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO) INSTRUCTIONS

*EXTERNAL REVIEW PROCESS NEWS: http://www.tdi.texas.gov/bulletins/2011/cc50.html

This form is being provided to you because your request for health care services has been denied as not medically necessary. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier. This is called an independent review by an independent review organization or "IRO."

You, your health care provider, or someone acting on your behalf may file this form.

Before you request an independent review you must first have appealed or requested reconsideration of the denial. Below are the time frames in which you must file for appeal or reconsideration:

- For **health cases**, the time limit imposed by the health plan for filing an appeal must be reasonable.
- For Workers' Compensation Non-Network cases, you must request reconsideration by the workers' compensation insurance carrier or Utilization Review Agent (URA) that made the decision within 15 working days after you received the first denial.
- For **Workers' Compensation Network cases**, you must request reconsideration by the workers' compensation insurance carrier or URA that made the decision within **30 calendar days**.

Exceptions:

- If you have a life threatening condition and services have not been received, you do not have to request an appeal or reconsideration before requesting an independent review.
- If you are an injured employee and have paid for services out of pocket, you do not have to request reconsideration before requesting an independent review.
- If you are an injured employee and services have been provided, you cannot request an independent review unless you have paid for the services.

Here is what you must do to request an independent review of your case:

- Complete the attached form (LHL009, Request for a Review by an Independent Review Organization).
- Sign the form so the IRO can receive your medical records (**Not required for Workers' Compensation cases**).
- Return the completed form to the company that sent you the denial letter as soon as possible. (For Workers' Compensation cases, you must return this form requesting an IRO within 45 calendar days). The company's address and/or fax number are either listed on page four of the form or on the denial letters. DO NOT SEND THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.

The company will forward your request for an IRO to the Texas Department of Insurance. Once the Texas Department of Insurance receives the request from the company, we will assign your case to an IRO. You will receive a letter from the Texas Department of Insurance identifying the IRO to whom your case has been assigned.

The IRO has 20 days to make a decision for non life threatening cases and 8 days to make a decision for life threatening cases. The IRO will notify you of its decision.

There is no cost to you for the independent review. (Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective IRO review will be required to pay the IRO fee prior to the IRO beginning its review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.)

You can call the Texas Department of Insurance (TDI) at 1-866-554-4926 for information if you have any questions about the independent review process.

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COMPLETE THIS FORM BY TYPING OR PRINTING THE INFORMATION WITH BLACK INK

	UEST FORM INDEPENDENT REVIEW ORGANIZATION			
T	Walter			
Today's Date: Month Day	Year			
Name of Party Requesting IRO:	Relationship to the Patient or Injured Employee: (Check one) □ Self			
Print Last Name, First Name and Middle Initial	 □ Person acting on behalf of patient or injured employee □ Provider acting on behalf of patient or injured employee □ Provider that received the denial 			
	☐ Sub claimant (Workers' Compensation only)			
	FOR REVIEW BY AN IRO			
Is the condition life-threatening?	Is the review ordered by a Court?			
Check one:	Check one:			
☐ Yes ☐ No	□ Yes □ No			
(This question does not apply if services have been receiv	, · ·			
DENIED 8	SERVICES			
Describe the health care services that are being denied (ir	oclude dates only if services have been performed):			
Describe the fleath oute services that are being defined (ii	iolado dates offiy il services flave been performed).			
PATIENT/INJURED EM	PLOYEE INFORMATION			
Health Plan or Claim Identification Number:				
(This number is usually found on the patient's ID card for health plans. The number identifies the patient to the insurance				
carrier. Enter the DWC claim number for workers' comper	nsation cases.)			
Date of Birth:(month) (day) (year)_	Sov			
Date of Bitti.(Month) (day) (year)_				
Social Security Number				
First NameMiddle Name	Last NameSuffix			
Street				
				
CityZip code				
Discussion				
Phone:Fax:				

THIS FORM MUST BE RETURNED TO THE COMPANY THAT ACTUALLY ISSUED THE DENIAL.

DO NOT RETURN THIS FORM TO TDI.

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COMPLETE THIS FORM BY TYPING OR PRINTING THE INFORMATION WITH BLACK INK

PROVIDER THAT RECEIVED THE DENIAL				
Name				
Federal Tax Identification Number				
Street				
City State Zip code				
Phone: Fax:				
PROVIDER ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF (IF APPLICABLE)				
Name				
Federal Tax Identification Number				
Street				
City State Zip				
Phone number:Fax number:				
PERSON ACTING ON PATIENT or INJURED EMPLOYEE'S BEHALF (IF APPLICABLE)				
First NameMiddle NameLast NameSuffix				
Relation to patient				
Street				
CityStateZip				
Phone number:Fax number:				

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COMPLETE THIS FORM BY TYPING OR PRINTING THE INFORMATION WITH BLACK INK

RELEASE (The release must be signed by the patient, or his or her legal guardian) (NOT REQUIRED FOR WORKERS' COMPENSATION CASES)				
I, (Print last name guardian <i>(circle one)</i> , authorize the release to the Inde other documents that are relevant to the review and ar hospital, or other health care provider.		n of all necess	sary medical records	s and
Signed	Date: (MO)	(day)	(yr.)	
Note: For chemical dependency or mental health to	reatment, please list the pro	viders to wh	ich this release ap	plies:
RETURN THIS FORM TO CARRIER/PAYOR OR UTILIZA	TION REVIEW AGENT			
Name of Company:				
Address:				
City: State:	Zip:			
Toll-Free Number: Fax	Number:			
You have the right to know about the information have a right to review or receive copies of info withhold information for reasons other than to pro	rmation about yourself, in			
You have the right to request that TDI correct info the Agency Counsel Section of TDI's Legal & Com also visit the Corrections Procedures section of TI	npliance Division at (512) 47	′5-1757 for m		

YOU CAN CALL THE TEXAS DEPARTMENT OF INSURANCE (TDI) AT 1-866-554-4926 FOR INFORMATION IF YOU HAVE ANY QUESTIONS ABOUT THE INDEPENDENT REVIEW PROCESS.

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