REQUEST FOR REVIEW BY THE OHIO DEPARTMENT OF INSURANCE

Name of person filing request for review by the Ohio Department of Insurance ____________________

Relationship to covered person ☐ Covered Person/Applicant
☐ Authorized Representative *(please complete the Appointment of Authorized Representative section)*

How would you like us to contact you? ☐ Phone ☐ Fax ☐ Email ☐ Mail

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Mailing Address	City	State	Zip code
Daytime Phone		Evening Phone	
Email Address		Fax	

COVERED PERSON/APPLICANT INFORMATION

Name		ID Number	
Mailing Address	City	State	Zip code
Daytime Phone		Evening Phone	
Email Address		Fax	

TREATING PHYSICIAN/HEALTHCARE PROVIDER INFORMATION

Name		Phone Number	
Mailing Address	City	State	Zip code
Email Address		Fax Number	
Contact Person		Phone Number	

To complete this request for review, please fill out the additional information on the reverse side.

Review Specifications

Briefly describe why you disagree with the decision to deny your request for external review. You may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim.

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Appointment of Authorized Representative (Complete when someone else is representing you in this appeal.)
You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize ________________________ to pursue my review by the Ohio Department of Insurance on my behalf.

____ ________________________

Signature of Covered Person (or legal representative*) Date

Signature and Release of Medical Records

To appeal the external review denial, you must sign and date this Request for Review by the Ohio Department of Insurance Form and consent to the release of medical records.

I,____ , hereby request a review of the external review denial. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider and/or health plan issuer to release all relevant medical or treatment records to the Ohio Department of Insurance. I understand that the Ohio Department of Insurance will use this information to make a determination on my request for review of the denial and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

____ ________________________

Signature of Covered Person (or legal representative*) Date

*Parent, Guardian, Conservator or Other - please specify

Send this form and a copy of your notice of denial of external review request for administrative reasons to one of the following:

Mailing Address:
Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, OH 43215

Phone Number: 1-800-686-1526 / 614-644-2658
TDD: 614-644-3745
Fax Number: 614-644-3744

Be certain to keep copies of this form, your Notice of Denial of External Review Request for Administrative Reasons and all documents and correspondence related to this review.