AULTCARE AULTRA

EXTERNAL REVIEW REQUEST FORM

Name of person filing request for external review _____

Relationship to covered person ☐ Covered Person/Applicant

☐ Authorized Representative *(please complete the Appointment of Authorized Representative section)*

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		

External Review Specifications

1. If your situation is urgent, are you requesting an expedited review?* ☐ Yes ☐ No

*If you answer yes, your physician must certify your condition could, in the absence of immediate medical treatment, result in the following:

- Seriously jeopardize your life or health or your ability to regain maximum function, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Is your requested healthcare service considered an experimental or investigational treatment?** ☐ Yes ☐ No

**If you answer yes, your physician must certify that they are requesting authorization for a drug, device, procedure, or therapy denied for coverage due to the determination that the treatment is experimental and/or investigational and your medical condition meets certain requirements:

- Standard healthcare services have not been effective in improving your condition.
- Standard healthcare services are not medically appropriate for you.
- There is no available standard healthcare service covered by the health plan issuer that is more beneficial than the requested healthcare service.

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

_____

_____

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 external review on my behalf.

_____ _____

Signature of Covered Person (or legal representative*) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I hereby request an external review. 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 Independent Review Organization and/or the Ohio Department of Insurance. I understand that the Independent Review Organization and the Ohio Department of Insurance will use this information to make a determination on my external review 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 final adverse benefit determination to one of the following:

Mailing Address:
Grievance and Appeal Coordinator
P.O. Box 6029 Canton, OH 44706

Fax Number: 330-363-3066

Email Address: Aappeals@aultcare.com

Be certain to keep copies of this form, your Notice of Final Adverse Benefit Determination, and all documents and correspondence related to this claim.

English
If you, or someone you are helping, have questions about **AultCare/Aultra** you have the right to get help and information in your language at no cost. To speak with an interpreter, call **Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 711 Outside Stark County: 711**

Spanish
Español
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca **AultCare/Aultra** tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al **Local : 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 711 Fuera del condado de Stark : 711**

Chinese
中文
如果您，或是您正在協助的對象，有關於 **AultCare/Aultra 保險公司** 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 本地： **330.363.6360 斯塔克縣外： 1.800.344.8858 TTY 線 本地： 711 斯塔克縣外： 711。**

German
Deutsche
Falls Sie oder jemand, dem Sie helfen, Fragen zum **AultCare/Aultra** haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 711 Außerhalb von Stark County : 711** an.

Arabic
العربية
العربية، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب **AultCare/Aultra**إن كان لديك أو لدى شخص تساعده أسئلة بخصوص شركة التأمين
خارج مقاطعة ستارك .**711** المحلي: **711**الخط **TTY** خارج مقاطعة ستارك : **330.363.6360 1.800.344.8858**

Pennsylvania Dutch
Deitsch
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut **AultCare/Aultra** hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du **Local: 330.363.6360 Außerhalb von Stark County: 1.800.344.8858 TTY –Linie Local: 711 Außerhalb von Stark County : 711** uffrufe.

Russian
русский
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу **Страховая компания AultCare/Aultra**, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 711 Вне Старка County : 711.**

French
Français
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de **Compagnie d'Assurance AultCare/Aultra**, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, **Appelez Locale 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 711 En dehors du comté de Stark : 711**.

Vietnamese
Việt Nam
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về **Công ty Bảo hiểm AultCare/Aultra** quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 711 Bên ngoài của Stark County : 711.**

Cushite-Oromo
Isin yookan namni biraa isin deeggartan **AultCare/Aultra,** irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 711 Outside of Stark County: 711** tiin bilbilaa.

Korean
한국어
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 **AultCare/Aultra 보험 회사** 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 **지역 : 330.363.6360 스타크 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 711 스타크 카운티 의 외부 : 711**
로 전화하십시오.

Italian
Italiano
Se tu o qualcuno che stai aiutando avete domande su **AultCare/Aultra**, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente.
Per parlare con un interprete, puoi chiamare **Locale: 330.363.6360 Al di fuori di Stark County : 1.800.344.8858 TTY linea Locale: 711 Al di fuori di Stark County : 711.**

Japanese
日本語
ご本人様、またはお客様の身の回りの方でも **AultCare/Aultra** 保険会社についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、
ローカル： **330.363.6360** スターク郡の外： **1.800.344.8858 TTY** ライン ローカル： **711** スターク郡の外： **711** までお電話ください。

Dutch
Nederlands
Als u, of iemand die u helpt, vragen heeft over **AultCare/Aultra,** heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten.
Om te praten met een tolk, bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 711 Buiten Stark County : 711.**

Ukrainian
український
Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про **Страхова компанія AultCare/Aultra,** у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на **Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 711 Поза Старка County : 711.**

Romanian
Română
Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind **Compania de Asigurari AultCare/Aultra**, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 711 In afara Stark Judet : 711.**

Non-Discrimination Notice:

AultCare/Aultra complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AultCare/Aultra does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AultCare/Aultra provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). AultCare/Aultra provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, or if you believe that AultCare/Aultra has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: AultCare/Aultra Civil Rights Coordinator, 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, CivilRightsCoordinator@aultcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building Washington, D.C. 20201. 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.