# *STATE OF MINNESOTA*
# *DEPARTMENT OF HEALTH*
## Request for External Appeal

### Enrollee Information

Enrollee Name: _____

Dependent Name (if appeal is on behalf of a person other than the health plan policy holder): _____

_____

Enrollee Address[1]: _____
Street Address

_____
City State Zip Code

Enrollee Phone: Day: _____ Email: _____

Enrollee Insurance ID#: _____

YOU HAVE THE RIGHT TO PICK A PERSON TO REPESENT YOU IN YOUR APPEAL. IF YOU CHOOSE TO BE REPRESENTED BY SOMEONE, YOU MUST COMPLETE AND SIGN THIS SECTION TO APPOINT A REPRESENTATIVE[2]:

### Enrollee Representative Information (Optional)

Representative Name: _____

Relationship to Enrollee: _____

Representative Address: _____

Representative Phone: _____

I am the "enrollee" identified above and I authorize the person (identified above) to represent me in my external appeal.

Enrollee Signature: _____

**Health Plan or Utilization Review Company Information** (Enter the name of the company that denied your claim.)

Health Plan Name: _____

Health Plan Address: _____
_____

**Denied Service/Summary of Appeal** (Enter a brief description of the claim, request, treatment or service you believe was denied and why you are appealing this denial. Attach a copy of the denial issued by the insurer.)

**Additional Information** (Note: Your health plan will be asked to send the reviewing entity the complete record of your appeal, including any information you have already given them. However, you can include with this form any letters, documents or description that you want to send us.)

CHECK: ___ I am ___ I am not, including additional information.

[1] Write the address we should use to send you mail about your case.
[2] An enrollee signed authorization is not required if the enrollee is not competent and is represented in compliance with Minnesota Law.

**Expedited (Fast, 72 hour) Appeal** A normal appeal can take 45 days. If you and a health care professional believe the time involved in the normal appeal process could harm your health, you may get an expedited 72-hour appeal. A health care professional must agree you need a fast appeal. Enter the information on this professional:

Health Care Professional's Name: _____

Health Care Professional's Address: _____

_____

Other Person in Health Care Professional's Office To Contact (Optional): _____

Health Care Professional's Phone: _____

**Appeal Filing Fee** (You must pay a fee of $25, unless you apply for and receive a waiver. You will not get the fee back if you start or if you lose your appeal.)

CHECK: ___ Yes, I have enclosed a check for $25, made payable to: **Minnesota Department of Health**

___ No, I am applying for a hardship waiver

**Hardship Waiver of $25** (The State may waive the $25 filing fee, if you have a hardship and are unable to pay it. Fill out this Section)

Number of people in your family: _____ Approximate gross monthly family income: _____

Reason for claiming financial hardship: _____

## Assistance and Counseling

If you have questions about this external appeal process, contact the State of Minnesota Health Department at 1-800-657-3916.

## Mediation Option **(Not Available for Expedited Cases)**

The external appeal review organization decides most appeals based on the written information submitted by you and the health plan. In mediation you and the health plan talk about the the appeal and try to resolve it (by phone or in person) with a trained mediator. If you and the health plan request mediation, the external appeal review organization decides if mediation is appropriate for your case.

Check: ___ I request mediation ___I do not want mediation ___I want more information

## Information on Use of Data

The information you are providing is needed to process your request for external review, and to provide the information necessary for the external appeal review organization to review your case and reach a decision. You are not legally required to provide any data to the Department of Health and you may refuse to provide any data. If the Department of Health identifies the need to conduct its own investigation of your complaint, we will contact you directly to discuss our investigation process and obtain any required information. The Department of Health will make available summary data on the decisions made by the external appeal review organization, including the number of reviews heard and decided and the final outcomes. The data will not individually identify the enrollee making the request for external review.

## Signature and Release of Person Requesting Appeal

I promise that all of the information on this form is true to the best of my knowledge, that I am enrolled in the above health plan and that I have gone through my health plan's internal appeal process. I authorize my health plan and my medical providers to release my medical records to the external appeal review organization solely for the purpose of processing my appeal. This consent will be revoked upon the conclusion of this external review and appeal.

Enrollee signature: _____ Date: _____

Mail to: Minnesota Department of Health, Attn: Managed Care Systems Section, P.O. Box 64975, St. Paul, MN 55164-0975 or
Email: Health.mcs@state.mn.us