Request for External Review – Kentucky Members

Please review this form carefully as it provides details about the External Review process specifically for Kentucky Members.

External Review is used when a Member disagrees with the benefit decision that HRI made when paying a claim. This is called an Adverse Determination. Covered Members can request an External Review by a third-party organization called an Independent Review Entity (IRE) to review the decision made by HRI. The IRE's that are available to review the Adverse Determination are provided by the Kentucky Department of Insurance.

The Member or Authorized Representative must complete this form and submit to HRI to start the External Review process.

Submit to:
HRI Dental & Vision
P.O. Box 659
Evansville, Indiana 47704-0659
Email: claims@insuringsmiles.com

HRI will review the submission and if it meets eligibility requirements will submit to an IRE.

The Member is responsible for paying the IRE $25 for the External Review. If the IRE finds in the Member's favor, the $25 will be refunded to the Member.

To qualify for External Review, the Adverse Determination must have occurred within 4 months of the request for External Review. Member must have been covered at the time of service provided and the cost of treatment is at least $100.

Most reviews will follow a standard review process that takes 3-4 weeks after all records are received. If a Member is hospitalized or if the treating dental provider believes that an Expedited Review is necessary for the treatment of immediate medical needs that could put the Member's health in jeopardy, cause a serious impairment to bodily function or serious dysfunction of a body part.

At any time, you can contact HRI Member Services at 800-727-1444 for answers to your questions related to this process.

Keep copies of this form, your Adverse Determination, and all documentation for your records.

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HRI Dental & Vision
1449 Kimber Lane, Suite 103A
Evansville, Indiana 47715
800-727-1444
Insuringsmiles.com

KENTUCKY – EXTERNAL APPEALS REQUEST

Please complete all request for information

Name of person filing request for External Review: _____

Relationship _____ Covered Member _____ Authorized Representative

Member Name (if different from requester): _____

Member #: _____

Requester Contact Information:

Mailing Address: _____

Phone: _____

Email Address: _____

Covered Member Contact Information:

Mailing Address: _____

Phone: _____

Email Address: _____

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Treating Dentist/Health Care Provider:

Name: _____

Mailing Address: _____

Phone: _____

Fax: _____

Email Address: _____

Provide Answers to Questions 1 & 2:

1. Is Member currently hospitalized or in the absence of immediate medical attention, result in placing the Member's health or the health of Member's unborn child in serious jeopardy, cause serious impairment of Member's bodily functions, or cause Member serious dysfunction of a bodily organ or part?

   ____ Yes _____ No

   If the answer is "Yes", this will qualify for an "Expedited External Review". HRI will reach out to the Healthcare Provider to confirm the need.

2. Briefly describe why Member disagrees with the Adverse Benefit Determination. Please attach any supporting health care provider letters, bills, dental or medical records or other documents supporting the request:

   _____

   _____

   _____

   _____

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Consent to Release Medical Records

To request an External Review of your Adverse Benefit Determination, you must sign and date this form and consent to the release of your dental/medical records. If you are requesting an Expedited External Review of your Final Adverse Benefit Determination.

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 dentist, health care provider, and/or HRI to release all relevant dental/medical or treatment records to the Independent Review Entity, the Kentucky Department of Insurance, and/or HRI. I understand that the Independent Review Entity 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. 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

Appointment of Authorized Representative

(Member, please complete this authorization when someone else is representing you in this External Review):

You may represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I, _____ **(Insert Name of Member**), appoint _____ **(Insert Name of Authorized Representative),** to act on my behalf in connection with any claim for coverage or benefits identified in this case, including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me and to provide any information to the health plan in relation to the disputed claims, approvals, or authorizations.

_____

Signature of Covered Person (or legal representative*) Date

*Parent, Guardian, Other—please specify

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I, _____ **(Insert Name of Authorized Representative),** hereby accept the above appointment. I am a/an _____ (**Insert Relationship to Member**).

_____

Signature of Authorized Representative Date

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