INDEPENDENT MEDICAL REVIEW REQUEST

Please read this form in its entirety. Any relevant information, including appeal letters, medical records, doctor's notes, or test results should be attached to this request. You have a right to provide documentation, and the insurance company must provide your entire claim file for their denial. We cannot proceed with your request without adequate information to identify the claim in question as well as complete contact information for the patient or authorized representative, requested below.

Once initiated, you will receive a confirmation letter which details the time limits for providing additional information regarding your claims. You must provide any documentation immediately if you wish for it to be considered by the independent review organization. Please feel free to contact our office with questions about this process.

AUTHORIZATION

Patient's Name: ____

Policyholder's Name (if different): ____

Insurance Company Name: ____

Policy Number: ____

Type of Service Being Denied: ____

Contact Person/Authorized Representative: ____

Phone Number and Email Address for Contact: _____________________________________

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I, ____, hereby request an external review pursuant to KSA 40-22a13 through 40-22a16, with respect to the claim dispute referred to in the attached correspondence. I authorize the Kansas Insurance Department to obtain copies of any and all documents including, but not limited to, medical records and reports; notes; charts; lab reports; x-ray reports and x-ray films; consultations and evaluations; tests and test results; prescriptions; bills; correspondence from any physician, attorney, hospital, patient, etc.; and all other documents pertaining to the patient as it relates to the subject dispute. I further authorize the Kansas Insurance Department to release copies of such documentation to the External Review Organization designated by them to conduct the external review, as provided in the aforementioned law.

A photocopy of this form shall have the same force and effect as the original.

Dated: _________, 20____

Signed_____________________________________ (Patient or Authorized Representative)