# Request for External Review

**National External Review Unit**
Toll-free Number: 877-848-5855
Fax Number: 860-975-1526

## Instructions

1. Once eligible Members have completed the applicable appeal process, they may request review of coverage denials that were based upon lack of medical necessity or the experimental or investigational nature of the requested or proposed service or supply by an independent review organization (IRO). Members must submit requests for external review within the timeframe specified in the final coverage denial letter.
2. A copy of the coverage denial, as well as all other information the Member wishes to be considered by the IRO, must be attached to this form. The determination of the IRO will be based on the information submitted and the terms and conditions of the Member's benefit plan. Aetna will provide to the IRO the materials utilized during the coverage decision review process including the terms and conditions of the Member's benefit plan.
3. Send this completed form and **all** other information to: **Aetna Health and/or Aetna Life Insurance Company**
   **National External Review Unit**
   **11675 Great Oaks Way**
   **Alpharetta, GA 30022**

## Member Information

| Member Name | Member ID Number |
|---|---|
| Member Address (Street, City, State, ZIP) | |
| Member Telephone Numbers<br>Home ( ) - | Work ( ) - |

## Provider Information

| Treating Healthcare Provider Name | |
|---|---|
| Address (Street, City, State, ZIP) | |
| Provider Telephone Numbers<br>Office ( ) - | Fax ( ) - |

## Request for External Review

Member requests External Review for coverage determination involving:

**NOTE:** Attach copy of coverage denial and all other information you wish to have considered.

## Signature(s)

By signing below, the Member consents to release by Aetna or an affiliated entity and the Member's healthcare providers of all confidential medical information to the IRO and its reviewers for the purpose of reviewing the coverage denial. This consent includes consent to release all confidential information relating to mental/behavioral health, substance abuse and HIV/AIDS, if applicable. This consent is valid for one year, and may be revoked at any time upon written notice to Aetna. I understand that another person may request External Review on my behalf with my consent. If I have such person sign below, I consent to having such person ("My Authorized Representative") request External Review on my behalf and to receive all communications related thereto.

| **Signature of Member (or Legal Representative*)** ***Parent, Guardian, Conservator, or Other – Please specify:** | Telephone Number |
|---|---|
| Printed Name | Date |
| **Signature of Authorized Representative** | Telephone Number |
| Printed Name | Date |
| Authorized Representative Address (Street, City, State, ZIP) *(if different than Member Address)* | |

Certain states mandate separate external review processes, external review of additional benefits or services, may require a filing fee, or a different form. Contact Member Services at the number listed on your identification card or you may also call your state insurance or health department for additional information regarding state mandated external review procedures. These state mandates may not apply to self-funded plans. Further information regarding external review can be found on our website (www.aetna.com) and by calling Member Services.