REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)
INSTRUCTIONS

*EXTERNAL REVIEW PROCESS NEWS: http://www.tdi.texas.gov/bulletins/2011/cc50.html

This form is being provided to you because your request for health care services has been denied as not medically necessary. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier. This is called an independent review by an independent review organization or "IRO."

You, your health care provider, or someone acting on your behalf may file this form.

Before you request an independent review you must first have appealed or requested reconsideration of the denial. Below are the time frames in which you must file for appeal or reconsideration:

- For **health cases**, the time limit imposed by the health plan for filing an appeal must be reasonable.
- For **Workers' Compensation Non-Network cases**, you must request reconsideration by the workers' compensation insurance carrier or Utilization Review Agent (URA) that made the decision within **30 days** after you received the first denial.
- For **Workers' Compensation Network cases**, you must request reconsideration by the workers' compensation insurance carrier or URA that made the decision within **30 calendar days.**

Exceptions:
- If you have a life threatening condition and services have not been received, you do not have to request an appeal or reconsideration before requesting an independent review.
- If you are an injured employee and have paid for services out of pocket, you do not have to request reconsideration before requesting an independent review.
- If you are an injured employee and services have been provided, you cannot request an independent review unless you have paid for the services.

Here is what you must do to request an independent review of your case:

- Complete the attached form (LHL009, Request for a Review by an Independent Review Organization).
- Sign the form so the IRO can receive your medical records (**Not required for Workers' Compensation cases**).
- Return the completed form to the company that sent you the denial letter as soon as possible. **(For Workers' Compensation cases, you must return this form – requesting an IRO – within 45 calendar days).** The company's address and/or fax number are either listed on page four of the form or on the denial letters. **DO NOT SEND THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.**

The company will forward your request for an IRO to the Texas Department of Insurance. Once the Texas Department of Insurance receives the request from the company, we will assign your case to an IRO. You will receive a letter from the Texas Department of Insurance identifying the IRO to whom your case has been assigned.

The IRO has 20 days to make a decision for non life threatening cases and 8 days to make a decision for life threatening cases. The IRO will notify you of its decision.

There is no cost to you for the independent review. (**Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective IRO review will be required to pay the IRO fee prior to the IRO beginning its review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.)**

You can call the Texas Department of Insurance (TDI) at 1-866-554-4926 for information if you have any questions about the independent review process.

Pursuant to 28 TAC §19.1710, this form is prescribed by TDI.

COMPLETE THIS FORM BY TYPING OR PRINTING THE INFORMATION WITH BLACK INK

REQUEST FORM
REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Today's Date: Month_____ Day_____ Year_____

Name of Party Requesting IRO: _____ **Print Last Name, First Name and Middle Initial**	**Relationship to the Patient or Injured Employee:** **(Check one)** ☐ Self ☐ Person acting on behalf of patient or injured employee ☐ Provider acting on behalf of patient or injured employee ☐ Provider that received the denial ☐ Sub claimant (Workers' Compensation only)

REASON FOR REQUEST FOR REVIEW BY AN IRO

Is the condition life-threatening? Check one: ☐ Yes ☐ No (This question does not apply if services have been received)	Is the review ordered by a Court? Check one: ☐ Yes ☐ No

DENIED SERVICES

Describe the health care services that are being denied (include dates only if services have been performed):

_____

PATIENT/INJURED EMPLOYEE INFORMATION

Health Plan or Claim Identification Number:_____
(This number is usually found on the patient's ID card for health plans. The number identifies the patient to the insurance carrier. Enter the DWC claim number for workers' compensation cases.)

Date of Birth:*(month)* _____ *(day)* _____ *(year)*_____ Sex_____

Social Security Number _____-_____-_____

First Name_____Middle Name _____ Last Name _____Suffix_____

Street _____

City_____ State_____ Zip code_____

Phone: _____-_____ Fax: _____-_____

THIS FORM MUST BE RETURNED TO THE COMPANY THAT ACTUALLY ISSUED THE DENIAL.

DO NOT RETURN THIS FORM TO TDI.

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PROVIDER THAT RECEIVED THE DENIAL

Name_____

Federal Tax Identification Number _____

Street_____

City_____ State_____ Zip code_____

Phone: _____-_____ Fax: _____-_____

PROVIDER ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF *(IF APPLICABLE)*

Name_____

Federal Tax Identification Number _____

Street_____

City_____ State_____ Zip _____

Phone number: _____-_____Fax number: _____-_____

PERSON ACTING ON PATIENT or INJURED EMPLOYEE'S BEHALF *(IF APPLICABLE)*

First Name_____Middle Name _____Last Name _____Suffix_____

Relation to patient _____

Street_____

City_____State_____Zip _____

Phone number: _____-_____Fax number: _____-_____

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RELEASE (The release must be signed by the patient, or his or her legal guardian)
(NOT REQUIRED FOR WORKERS' COMPENSATION CASES)

I,_____ (**Print last name, first name and middle initial)**, the patient, parent, or patient's legal guardian ***(circle one)***, authorize the release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed_____ Date: *(MO)* _____ *(day)* _____*(yr.)* _____

Note: For chemical dependency or mental health treatment, please list the providers to which this release applies:

_____

_____

_____

_____

_____

RETURN THIS FORM TO CARRIER/PAYOR OR UTILIZATION REVIEW AGENT

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Toll-Free Number: _____ Fax Number: _____

You have the right to know about the information the Texas Department of Insurance (TDI) collects about you. You have a right to review or receive copies of information about yourself, including private information. TDI may withhold information for reasons other than to protect your right to privacy.

You have the right to request that TDI correct information that TDI has about you that is incorrect. Please contact the Agency Counsel Section of TDI's Legal & Compliance Division at (512) 475-1757 for more information. You may also visit the Corrections Procedures section of TDI's web page at www.tdi.state.tx.us

YOU CAN CALL THE TEXAS DEPARTMENT OF INSURANCE (TDI) AT 1-866-554-4926 FOR INFORMATION IF YOU HAVE ANY QUESTIONS ABOUT THE INDEPENDENT REVIEW PROCESS.

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