Request for Independent External Review of Carrier's Adverse Determination

Name of Insured/Member: _____

Designated Representative (if any): _____
Note: A copy of the written authorization must be attached/enclosed.

Address: _____

Phone: _____ Fax: _____

Member ID #: _____

Important: A copy of your carrier's written notification of the final adverse determination must be attached/enclosed.

- ❑ **Check here if requesting an expedited review and attach required physician's certification.**
- ❑ **Check here if attaching new information not considered in previous appeal reviews.**

I hereby authorize Denver Health Medical Plan, Inc. to disclose protected health information, including medical records, pertinent to the external review to the assigned independent external review entity.

Signature: _____ **Date:** _____

SUBMIT BY MAIL OR FAX TO:

Contact Name:	Grievance and Appeal Department
Carrier Name:	Denver Health Medical Plan, Inc.
NAIC Number:	95750
Address:	777 Bannock St., MC6000
	Attn: Grievance & Appeal Dept.
City/State/Zip:	Denver, CO 80204
Phone:	303-602-2261
Fax:	303-602-2078