CONSENT TO NAME AN AUTHORIZED REPRESENTATIVE TO PURSUE AN APPEAL OF AN ADVERSE BENEFITS DETERMINATION INVOLVING MEDICAL JUDGEMENT

&

AUTHORIZATION TO RELEASE INFORMATION RELATING TO THE APPEAL

I[1], _____, by signing below, agree to representation by the following authorized representative,_____, to act on my behalf in an appeal of an adverse benefits determination involving medical judgment as allowed by the Patient Protection and Affordable Care Act (PPACA) Public Law 111-148, and Section 2719 of the Public Health Services Act (PHS Act) which PPACA has incorporated into the Employment Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code), making those provisions applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. I also agree to the release of my personal health information to my appointed authorized representative named herein, to Horizon BCBSNJ and its independently contracted Independent Review Organization (IRO) that will review my appeal. My consent to this appointment of this authorized representative and my authorization of release of my personal health information expires in 24 months, but I may revoke both sooner.

Signature:_____ Ins. ID#:_____ Date:_____

Relationship to Patient: [x] I am the patient [ ] I am a Personal Representative

[1] If the patient is a minor, or unable to read and complete this form f due to mental or physical incapacity, a personal representative of the patient may complete this form.

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by ☐ and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS:_____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.