COMMUNITY HEALTH CHOICE
2636 S LOOP WEST, STE 125
HOUSTON, TX 77054

MEMBER PORTAL
1025 W NAVITUS DR.
APPLETON, WI 54913

04/24/2020

Patient Name: MEMBER PORTAL
Date of Birth: 8/1/1992
ID Number: S000000236100*NVCHX
Medication Requested: MODAFINIL
Request Date: 04/24/2020
Decision Date: 04/24/2020
Requesting Provider: ONLY PAXUSE
Provider Fax: (555) 555-5555
Reviewer: Beverly Grimshaw, MD - Medical Director

We reviewed your doctor's request for the above drug. We are not able to approve this drug. Your doctor had a reasonable opportunity to discuss the plan of treatment for you with a doctor before the denial was made. It does not meet the approval criteria.

TEST This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, the following caused the denial.
[1) This drug is being used for [INSERT DIAGNOSIS]. This is not an approved use.
2) All formulary drugs used for your condition have not been tried and failed. Other drugs that can be used are [INSERT FORMULARY ALTS].
3) Records showing medical history and past treatments were not received.
4) Samples of this drug were used to start your treatment.]
Please look at the formulary for a list of covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number [INSERT #] of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.

3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
4) Prescription drug samples were not used to establish treatment.
Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. **TEST**

This adverse determination was made by a Beverly Grimshaw, MD - Medical Director. We told your doctor about this decision. Your doctor may have more information. If your doctor has more information, we can review the documentation. Please contact your doctor for more information.

Filing an Appeal

If you do not agree and would like to appeal this decision, you or an individual acting on your behalf or the provider of record may request an appeal orally or in writing at any time. Timely submission of the request will facilitate the processing of your appeal. Please direct your request to any of the following:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 125
Houston, Texas 77054
Phone: 713-295-6704 or 1-855-315-5386 or TTY 711
Fax to: 713-295-7033/Attn: Appeals Coordinator

Who May File An Appeal

1. The member may file an oral or written request for an appeal.
2. The member's provider of record or
3. A person acting on the member's behalf.

Standard (30 calendar days) and Expedited (1 business day) Appeal Process

1. An acknowledgement letter will be sent within 5 working days of our receipt of the appeal.

2. Standard Appeal: We have 30 calendar days to process a standard appeal of a service denial. An appeal response letter explaining the decision will be provided.

3. Expedited Appeal: An expedited appeal may be obtained, for denials of emergency care, life-threatening conditions and continued stays for hospitalized members. The review will be done by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review. An expedited appeal must be completed based on the immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the appeal is received. An expedited appeal determination may be provided by telephone or electronic transmission, but will be followed with a letter within three working days of the initial telephonic or electronic notification. If you would like to request an expedited appeal, specifically state that you want an expedited appeal or that you believe the member's health could be seriously harmed by waiting for the standard appeal.

4. Appeal decisions are made by a physician who has not previously reviewed this case and is of the same or similar specialty as your physician.

5. If the appeal is denied and, within 10 business days from the denial, your doctor gives us in writing good cause for having a particular type of specialty provider review the case, the denial will be reviewed by a physician in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse

determination. The specialty review will be completed within 15 working days of receipt of the request. This notification of the appeal must be in writing.

Independent Review Organization

If we deny the appeal (continue to deny the services or treatment described above), the Enrollee or someone acting on the enrollee's behalf and the provider or record have the right to request a review by an Independent Review Organization (IRO). The IRO does not have an affiliation with your health plan or health care providers. You can request an IRO review at any time; however, try to request the review as soon as possible. An IRO works with the Texas Department of Insurance. An IRO makes decisions on medical necessity and whether your care is appropriate.

You have the right to a review of an appeal by an Independent Review Organization (IRO) for urgent or life threatening conditions.

To request the independent review, fill out the enclosed TDI form (LHL009) and return it to:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Ste. 125
Houston, TX 77054
713-295-6704 or toll-free at 1-855-315-5386 or TTY 711
Fax to: 713-295-7033/Attn: Appeals Coordinator

The enrollee, parent, or the enrollee's legal guardian must sign the consent to release medical information to the IRO (included as part of the IRO form).

Utilization Review Complaint

If you have a complaint regarding the utilization review, please direct your request to any of the following:

Community Health Choice, Inc.
Attention: Service Improvement
2636 South Loop West, Suite 125
Houston, Texas 77054
Phone: 713-295-6704 or 1-855-315-5386 or TTY 711
Fax to: 713-295-7034/Attn: Service Improvement

We will review your complaint. We will send you a letter within 5 (five) business days lettering you know that we have received your compliant. Once we receive your compliant, we will investigate it and respond with a written letter within 30 calendar days.

You have the right to complain to the Texas Department of Insurance (TDI). You may contact TDI at the following address, telephone numbers, or website:

Texas Department of Insurance
P.O. Box 149091
Austin, Texas 78714-9091
1-800-252-3439
Fax: 512-490-10047
Online: www.tdi.texas.gov

Sincerely,

Beverly Grimshaw, MD - Medical Director

Enclosures: IRO; Notice of Adverse Determination

cc: ONLY PAXUSE

Si usted no entiende los contendios de esta carta, por favor llama a Servicios para los Miembros a 1-844-268-9788 y alguien la ayudara.

TEXAS DEPARTMENT OF INSURANCE
Financial Regulation Division - Managed Care Quality Assurance (103-6A)
333 Guadalupe, Austin, Texas 78701 ☆ PO Box 149104, Austin, Texas 78714-9104
(512) 676-6400 | F: (512) 490-1013 | (866) 554-4926 | TDI.texas.gov | @TexasTDI

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

(DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE)

Instructions to Patient, Person Acting on Behalf or Representative of Patient/Employee, and Provider:
This form is being provided to you because your request for health care services has been denied as not medically necessary by your insurance carrier. 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 (company). This is called an independent review by an Independent Review Organization or "IRO." You, your health care provider, or someone acting on your behalf or representative may file this form.

To request an independent review of your case, you must take the following action:

- Complete the Request for a Review by an Independent Review Organization form (TDI Form LHL009).
- Sign the form so the IRO can receive your medical records. (A signature is not required for Workers' Compensation cases).
- RETURN THE COMPLETED FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES AS SOON AS POSSIBLE. (For Workers' Compensation cases, you must return this form within 45 calendar days).
  - Carrier instructions: Complete the "Company or URA That Denied Services" Section on page 4.
  - Note to patients: The company address and/or fax number can be found on the denial letter.

The company will forward your request for an independent review to TDI. Once TDI receives the request from the company, TDI will assign your case to an IRO. You will receive a letter from TDI identifying the IRO to whom your case has been assigned. The timeframes for an IRO's decision are as follows:

Coverage Types	Health	Workers' Compensation Network (WCN)	Workers' Compensation Non-Network (WC)
Life Threatening	3 days	8 days	8 days
Denial of Prescription Drugs or IntravenousInfusions - Concurrent	3 days	NA	NA
Denial of an exception request to aprescription drug step therapy protocol - Preauthorization	3 days	NA	NA
Non-Life ThreateningPreauthorization/Concur	20 days	20 days	20 days
Retrospective	20 days	30 days from receipt of IRO fee*	30 days from receipt of IRO fee**

*Carrier pays the fee.
**Requestor pays the fee. (However, if the requestor is an injured employee, carrier pays the fee.)
There is no cost to you for the independent review. **Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective independent 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.**

REQUEST FORM

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Today's Date: Month________________Day______________Year___________

Name of Party Requesting Independent Review:	**Relationship to the Patient or Injured Employee: (Check one)**
____ **Print Last Name, First Name and Middle Initial**	☐ Self (complete page 3, item A) ☐ Person acting on behalf of patient or injured employee (complete page 3, items A and C) ☐ Provider acting on behalf of patient or injured employee (complete page 3, items A and B) ☐ Provider that received the denial (complete page 3, item A) ☐ Sub claimant (Workers' Compensation only) (complete page 3, items A and C)

REASON FOR REQUEST FOR REVIEW BY AN IRO

APPLIES TO HEALTH AND WORKERS COMPENSATION CASES:	APPLIES TO HEALTH CASES ONLY:
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	Is this a denial of prescription drugs or intravenous infusions for which you are already receiving benefits? Check one: ☐Yes ☐ No Is this a denial of an exception request to a prescription drug step therapy protocol: 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_____

First Name___________________Middle Name_______________Last Name_________________Suffix______

Street ____

City___________________________State________Zip code_____________

Phone_______-________________Fax_______-______________________

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES. (DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)

A. PROVIDER THAT RECEIVED THE DENIAL
Name____
Federal Tax Identification Number ____________________________
Street____
City__________________________State______Zip code________
Phone________-_______________Fax________-________________

B. PROVIDER ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF IF APPLICABLE
Name____
Federal Tax Identification Number ____________________________
Street____
City_____________________________State______Zip ___________
Phone number:________-_______________Fax number:_______-_________________

C. PERSON ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF IF APPLICABLE
First Name________________Middle Name___________Last Name__________Suffix________
Relation to patient ______________________________________
Street____
City_____________________________State______Zip __________
Phone number________-_______________Fax number_______-_________________

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES. (DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)

RELEASE

(The release must be signed by the patient, or his or her parent or 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, list the providers to which this release applies:

____

____

____

COMPANY OR UTILIZATION REVIEW AGENT THAT DENIED SERVICES

(This section to be completed ONLY by the company or URA that denied services.)

Name of Company ____

Address ____

City_____________________________State______________________Zip ___________

Toll-Free Number___________________________Fax Number ______________________

The person requesting the independent review should submit this form to the company, as given, in this section. (Do not submit this form to TDI.)

NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled to be informed about the information the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please contact the Agency Counsel Section of TDI's General Counsel Division at (512) 676-6551 or visit the Corrections Procedure section of TDI's website at www.tdi.texas.gov.

FOR INFORMATION ABOUT THE INDEPENDENT REVIEW PROCESS, PLEASE CALL TDI AT 1-866-554-4926, OPTION 7.

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES. (DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)

Member Appeal Rights
(Marketplace)

You received a Notice of Adverse Determination. This means that Community has:

- denied or reduced the authorization of a service.

Standard Appeal Process

You have the right to appeal an Adverse Determination. Your Provider or someone else that you choose as your representative may also appeal. You have 180 days from the date of the adverse determination to file your appeal. You may request your appeal verbally or in writing. Please send your appeal to:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 125
Houston, Texas 77054
713-295-6704 or 1-855-315-5386

Fax to: 713.295.7033/Attn: Appeals Coordinator

During the Appeal Process

We will let you know we received your appeal within 24 hours if you are hospitalized. Notifcation will be provided by telephone or electronic transmission. If you are not hospitalized, written notifcation will be provided within fve (5) business days. Community may need additional information to help us with your appeal. The letter will include a list of documents that you, your representative, or Provider should send to Community for the appeal. You have the right to give us information that supports your appeal. You may review any information we use to make our decision.

Community will have someone review the appeal to make sure we have all the required information. Community will also have a doctor review your appeal. This doctor will be trained in treating your type of illness and will not be part of the original decision.

Answering your Standard Appeal

Community will answer your appeal within 30 calendar days after the date received. The written response will include:

- Reasons for the appeal decision
- Clinical basis for the decision
- Types of doctors that reviewed the appeal, including the specialty type
- Your right to a review by Texas Department of Insurance Independent Review Organization (IRO) and how to request an IRO
- Your right to request a copy of the guidelines used to make our decision (unless it is determined that the healthcare service provided or proposed is not covered for reasons other than an Adverse Determination. For example, it is not a covered beneft or it is expressly excluded).

You have a right to reasonable access and copies of all documentation upon request

Your provider has the right to ask for a specialty review within ten (10) days of our decision.

Expedited Appeal Process

You have the right to ask for an expedited appeal. This type of appeal is about emergencies, continued hospitalizations and life-threatening conditions. You can request an expedited appeal, either orally or in writing. Community will resolve your expedited appeal no later than 1 working day from the date all of the necessary information to complete the appeal is received. Community may provide the appeal determination by telephone or electronic transmission but you will receive a letter within three working days of the initial notification.

Appeal Denial - Review by an IRO

If Community denies your request for services after you have exhausted the Community Health Choice internal appeal process, you have the right to a review of an appeal by an Independent Review Organization (IRO) (unless it is determined, that the healthcare service provided or proposed is not covered for reasons other than an Adverse Determination; for example, it is not a covered beneft or it is expressly excluded). An independent review is when someone not employed by Community reviews your request for services. If your case involves urgent or life-threatening conditions, you will be entitled to an immediate appeal to an IRO without going through Community's internal appeal process. Community will send you information on how to request an IRO and the Request Form with the appeal response letter.

Retrospective Adverse Determinations

Adverse determinations related to retrospective reviews will be made within a reasonable period but not to exceed 30 days after the claim is received. The determination will be sent to the Provider, enrollee or a person acting on behalf of the enrollee in writing.

Complaint Process

If you wish to complain, please send your complaint to:

Community Health Choice, Inc.
Attention: Service Improvement
2636 South Loop West, Suite 125
Houston, Texas 77054
713-295-6704 or toll-free at 1.855-315-5386 or TTY 771
Fax to: 713-295-7034/Attn: Service Improvement

Community will respond to complaints within 30 calendar days of receipt.

You may also file a complaint with the Texas Department of Insurance:

Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091
1-800-252-3439
Fax: 512-490-1007
Online: www.tdi.texas.gov

MEMBER APPEAL FORM
(Marketplace)

Member Name: ____

Address: ____

City, State & Zip: ____

Phone Number: ____

Member Number: ____

Is this a:

_____ Standard Appeal _____Expedited Appeal _____IRO Review-Standard

_____ IRO Review for urgent or life-threatening conditions

Briefly describe your appeal:

____

____

____

____

____ ____________________________
Signature Date

Please send your form to the following:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 125
Houston, Texas 77054
713-295-6704 or 1-855-315-5386 or TTY 711

Fax to: 713-295-7033/Attn: Appeals Coordinator

You are not required to return the completed form but we encourage you to do so as it will help us to resolve your appeal.

FORMULARIO DE APELACIÓN PARA EL MIEMBRO
(Marketplace)

Nombre del Miembro: ____

Dirección: ____

Ciudad, estado y código postal: ____

Número de teléfono: ____

Número de Miembro: ____

Esta es una:

_____ Apelación estándar _____ Apelación acelerada _____ Revisión estándar de una IRO

_____ Revisión de una IRO para enfermedades urgentes o potencialmente mortales

Describa brevemente su apelación:

____

____

____

____

____________________________ ____________________
Firma Fecha

Envíe el formulario a la siguiente dirección:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 125
Houston, Texas 77054
713-295-6704 o gratis al 1-855-315-5386 or TTY 711

Por fax: 713-295-7033/Attn: Appeals Coordinator

No está obligado a devolverlo lleno, pero lo instamos a que lo haga porque de esta forma nos ayudará a resolver su apelación.

TEXAS DEPARTMENT OF INSURANCE
Financial Regulation Division - Managed Care Quality Assurance (103-6A)
333 Guadalupe, Austin, Texas 78701 ★ PO Box 149104, Austin, Texas 78714-9104
(512) 676-6400 | F: (512) 490-1013 | (866) 554-4926 | TDI.texas.gov | @TexasTDI

SOLICITUD PARA UNA REVISIÓN POR PARTE DE UNA ORGANIZACIÓN DE REVISIÓN INDEPENDIENTE (INDEPENDENT REVIEW ORGANIZATION –IRO, por su nombre y siglas en inglés) INSTRUCCIONES

(NO REGRESE ESTE FORMULARIO AL DEPARTAMENTO DE SEGUROS DE TEXAS)

Instrucciones para el Paciente, Persona que Actúa en Nombre del Paciente o Representante del Paciente/Empleado, y Proveedor: Este formulario se le ha proporcionado a usted debido a que su solicitud para obtener servicios de cuidados de salud ha sido denegada debido a que se ha considerado que dichos servicios no son médicamente necesarios. Ahora usted puede solicitar que su caso sea revisado por parte de un proveedor de servicios médicos que sea totalmente independiente de su plan de salud o de su aseguradora (compañía). Esto es llamado una revisión independiente por parte de una Organización de Revisión Independiente o una "IRO". Usted, su proveedor de servicios médicos, o alguien que actúe en su nombre o su representante pueden presentar este formulario.

Para solicitar una revisión independiente en su caso, usted debe tomar las siguientes medidas:

- Completar la Solicitud para una Revisión por parte de una Organización de Revisión Independiente (Formulario de TDI LHL009).
- Firmar el formulario para que la IRO pueda recibir sus expedientes médicos. (La firma no es requerida para los casos de Compensación para Trabajadores).
- REGRESAR LO ANTES POSIBLE EL FORMULARIO COMPLETO A LA COMPAÑÍA QUE ESTÁ DENEGANDO SU SOLICITUD PARA LOS SERVICIOS DE LOS CUIDADOS DE SALUD. (Para los casos de Compensación para Trabajadores, usted debe regresar este formulario dentro del lapso de tiempo de 45 días calendario).
  - Instrucciones para la Aseguradora: Complete la Sección "Compañía o Agente para la Revisión de Utilización (Utilization Review Agent –URA, por su nombre y siglas en inglés) que ha Denegado los Servicios" en la página 4.
  - Nota para los pacientes: La dirección y/o número de fax de la compañía puede ser encontrado en la carta de rechazo (denial letter, por su nombre en inglés).

La compañía enviará su solicitud para una revisión independiente a TDI. Una vez que TDI recibe la solicitud de la compañía, TDI asignará su caso a una IRO. Usted recibirá una carta de parte de TDI donde se identificará la IRO a la que su caso ha sido asignado. Los límites de tiempo para que una IRO emita una decisión son los siguientes:

Tipos de Cobertura	Salud	Red de Compensación para Trabajadores (Workers' Compensation Network –WCN, por su nombre y siglas en inglés)	Compensación para Trabajadores Fuera de la Red (Workers' Compensation Non-Network –WC, por su nombre y siglas en inglés)
Pone en Peligro la Vida	3 días	8 días	8 días
Denegación de Medicamentos con Receta o Infusiones Intravenosas – Concurrente	3 días	NA	NA
Denegación de la solicitud para la excepción del protocolo para una terapia en etapas/pasos – Pre autorización	3 días	NA	NA
No Pone en Peligro la Vida Pre autorización/Concurrente	20 días	20 días	20 días
Retrospectiva	20 días	30 días a partir de la fecha en que se recibe el honorario de la IRO*	30 días a partir de la fecha en que se recibe el honorario de la IRO**

*La aseguradora paga el honorario.
**El solicitante paga el honorario. (Sin embargo, si el solicitante es el empleado lesionado, la aseguradora paga el honorario.)

No hay costo alguno para su revisión independiente. **Excepción solamente para la Compensación para Trabajadores Fuera de la Red: Un proveedor de servicios médicos que solicita una revisión retrospectiva independiente estará obligado a pagar los honorarios de la IRO antes que la IRO comience su revisión. Sin embargo, si la IRO falla a favor del proveedor de servicios médicos, el proveedor de servicios médicos será reembolsado por la aseguradora la cantidad de los honorarios de la IRO.**

FORMULARIO DE SOLICITUD

SOLICITUD PARA UNA REVISIÓN POR PARTE DE UNA ORGANIZACIÓN DE REVISIÓN INDEPENDIENTE

Fecha del Día de Hoy: Mes________________Día______________Año__________

Nombre del Participante que Solicita la IRO:

____

Escriba en Letra de Molde su Apellido, Nombre, e Inicial

Relación con el Paciente o Empleado Lesionado: (Indique uno)

- ☐ Sí mismo (complete la página 3, sección A)
- ☐ Persona que está actuando en nombre del paciente o del empleado lesionado (complete la página 3, secciones A y C)
- ☐ Proveedor que está actuando en nombre del paciente o del empleado lesionado (complete la página 3, secciones A y B)
- ☐ Proveedor que recibió la negativa (complete la página 3, sección

RAZÓN DE LA SOLICITUD PARA LA REVISIÓN POR PARTE DE UNA IRO

APLICA A LOS CASOS DE SALUD Y COMPENSACIÓN PARA TRABAJADORES:

¿Pone en peligro la vida esta condición? Indique uno:
☐ Sí ☐ No
(Esta pregunta no aplica si los servicios ya han sido recibidos)

¿Ha sido ordenada la revisión por un tribunal? Indique uno:
☐ Sí ☐ No

APLICA SOLAMENTE A LOS CASOS DE SALUD:
¿Se trata de una denegación de medicamentos con receta o infusiones intravenosas por la cual usted ya está recibiendo beneficios?
☐ Sí ☐ No

¿Se trata de una denegación de la solicitud para la excepción del protocolo para una terapia en etapas/pasos?
Indique uno:
☐ Sí ☐ No

SERVICIOS DENEGADOS

Describa los servicios de cuidados de salud que han sido denegados (incluya las fechas solamente si los servicios ya han sido realizados):

INFORMACIÓN SOBRE EL PACIENTE/EMPLEADO LESIONADO

Número de Plan de Salud o Número de Identificación de la Reclamación:____
(Este número por lo general se encuentra en la tarjeta de identificación del plan de salud del paciente. El número identifica al paciente con la aseguradora. Ingrese el número de reclamación de DWC para los casos de compensación para trabajadores.)

Fecha de nacimiento:*(mes)*______________*(día)*_______*(año)*_____ Sexo_____

Nombre_________________Segundo Nombre________________ Apellido_______________Nombre Sufijo_____________

Calle____

Ciudad_______________________Estado__________Código Postal___________________

Teléfono:_______-__________________Fax:_______-_______________________________

REGRESE ESTE FORMULARIO A LA COMPAÑÍA QUE ESTÁ DENEGANDO SU SOLICITUD PARA LOS SERVICIOS DE CUIDADOS DE SALUD.
(NO REGRESE ESTE FORMULARIO AL DEPARTAMENTO DE SEGUROS DE TEXAS.)

A. PROVEEDOR QUE RECIBIÓ LA NEGATIVA

Nombre____

Número de Identificación de Impuestos Federales (Federal Tax Identification Number, por su nombre en inglés)

____

Calle____

Ciudad___________________________ Estado_______ Código Postal_______________

Teléfono: _______-_________________ Fax: ______-___________________________

B. PROVEEDOR QUE ESTÁ ACTUANDO EN NOMBRE DEL PACIENTE/EMPLEADO LESIONADO, SI ES QUE APLICA

Nombre____

Número de Identificación de Impuestos Federales (Federal Tax Identification Number, por su nombre en inglés)

____

Calle____

Ciudad___________________________ Estado_______ Código Postal________________

Número de Teléfono: ________-__________________ Número de Fax: ______-___________

C. PERSONA QUE ESTÁ ACTUANDO EN NOMBRE DEL PACIENTE/EMPLEADO LESIONADO, SI ES QUE APLICA

Nombre ___________________ Segundo Nombre_______________ Apellido _______________ Nombre Sufijo________

Relación con el paciente ____

Calle ____

Ciudad ____________________ Estado ______ Código Postal ______________________

Número de teléfono: ________-_____________ Número de fax: ______-_____________

REGRESE ESTE FORMULARIO A LA COMPAÑÍA QUE ESTÁ DENEGANDO SU SOLICITUD PARA LOS SERVICIOS DE CUIDADOS DE SALUD.

(NO REGRESE ESTE FORMULARIO AL DEPARTAMENTO DE SEGUROS DE TEX

ACUERDO PARA LA ENTREGA DE INFORMACIÓN
(El acuerdo debe ser firmado por el paciente, o por su tutor legal.)
(ESTO NO ES REQUERIDO PARA LOS CASOS DE COMPENSACIÓN PARA TRABAJADORES)

Yo,____________________________ (**Escriba en letra de molde el apellido, nombre e inicial)**, el paciente, padre/madre, o tutor legal del paciente ***(circule uno)***, autorizo que se le entreguen a la Organización de Revisión Independiente todos los expedientes médicos necesarios y otros documentos que sean relevantes para la revisión, que estén en poder del Agente para la Revisión de Utilización o cualquier médico, hospital, u otro proveedor de servicios médicos.

Firmado_______________________________ Fecha: *(mes)* _____ *(día)* ________*(año)* _____

Nota: Para el tratamiento por dependencia a sustancias químicas o salud mental, enliste el nombre de los proveedores para los cuales aplica este acuerdo:

____

____

____

____

COMPAÑÍA O AGENTE PARA LA REVISIÓN DE UTILIZACIÓN QUE DENEGÓ LOS SERVICIOS
(Esta sección debe ser completada SOLAMENTE por la compañía o URA que denegó los servicios)

Nombre de la Compañía: ____

Dirección: ____

Ciudad: ____________________________ Estado: __________________ Código Postal: ____________

Número de Teléfono Gratuito: _________________________ Número de Fax: ______________________

La persona que solicita la revisión independiente debe enviar este formulario a la empresa, según se indica en esta sección. (No envíe este formulario a TDI.)

AVISO SOBRE CIERTA INFORMACIÓN, LEYES Y PRÁCTICAS
Con pocas excepciones, usted tiene derecho a ser informado sobre la información que el Departamento de Seguros de Texas (TDI, por sus siglas en inglés) reúne sobre usted. Bajo las Secciones 552.021 y 552.023 del Código Gubernamental de Texas, usted tiene derecho a revisar o recibir copias de la información sobre usted, incluyendo información que es privada. Sin embargo, es posible que TDI no dé a conocer la información por razones diferentes a las de proteger su derecho a la privacidad. Bajo la Sección 559.004 del Código Gubernamental de Texas, usted tiene derecho a solicitar que TDI corrija la información incorrecta que TDI tiene sobre usted. Para obtener más información sobre el procedimiento y los costos para obtener información de TDI o sobre el procedimiento para corregir información que mantiene TDI, por favor comuníquese con la Sección de Asesoría de la Agencia de la División de Asesoría General de TDI al (512) 676-6551 o visite la sección para el Procedimiento de Correcciones en el sitio web de TDI en www.tdi.texas.gov.

PARA OBTENER INFORMACIÓN SOBRE EL PROCESO DE REVISIÓN INDEPENDIENTE, POR FAVOR LLAME AL 1-866-554-4926, OPCIÓN 7.REGRESE ESTE FORMULARIO A LA COMPAÑÍA QUE ESTÁ DENEGANDO SU SOLICITUD PARA LOS SERVICIOS DE CUIDADOS DE SALUD.
(NO REGRESE ESTE FORMULARIO AL DEPARTAMENTO DE SEGUROS DE TEXAS.)

Language Assistance

Community Health Choice, Inc. is required by federal law to provide the following information.

1. Arabic	هذا الإشعار لديها معلومات هامة. هذا الإشعار لديه معلومات هامة عن طلبك أو التغطية من خلال اختيار صحة المجتمع. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد تحتاج إلى اتخاذ إجراءات من قبل بعض المواعيد النهائية للحفاظ على التغطية الصحية الخاصة بك أو مساعدة مع التكاليف. لديك الحق في الحصول على هذه المعلومات والمساعدة في لغتك دون أي تكلفة. استدعاء 1.855.315.5386
2. Chinese	本通知有重要信息。本通知包含關于您透過Community Health Choice提交的申請或保險的重要訊息。請留意本通知內的 重要日期。您可能需要在截止日期之前采取行動，以保留您的健康保險或費用補貼。您有權免費以您的母語得到本訊息和 幫助。請撥電話1.855.315.5386.
3. English	This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.855.315.5386
4. French	Cet avis contient des informations importantes. Cet avis contient des renseignements importants sur votre demande ou votre couverture par l'entremise de Community Health Choice. Cherchez les dates clés dans cet avis. Vous devrez peut-être prendre des mesures à certaines dates pour conserver votre couverture santé ou vous aider avec les coûts. Vous avez le droit d'obtenir ces informations et d'aider dans votre langue sans frais. Appeler le 1.855.315.5386
5. German	Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag auf Krankenversicherung bzw. Ihren Versicherungsschutz mit Community Health Choice. Achten Sie auf wichtige Termine in dieser Mitteilung. Eventuell müssen Sie zu bestimmten Stichtagen Maßnahmen ergreifen, um die Beibehaltung Ihres Versicherungsschutzes bzw. finanzieller Unterstützung zu gewährleisten. Sie haben ein Recht auf die kostenfreie Bereitstellung dieser Informationen und weiterer Unterstützung in Ihrer Sprache. Rufen Sie an unter 1.855.315.5386.
6. Gujarati	આ નોટિસ મહત્વનું માહિતી છે. આ નોટિસ તમારી Community Health Choice અરજી અથવા કવરેજ સમુદાય આરોગ્ય ચોઇસ દ્વારા વિશે મહત્વની જાણકારી ધરાવે છે. આ નોટિસ કી તારીખો માટે જુઓ. તમે તમારા આરોગ્ય કવરેજ રાખવા અથવા ખર્ચ સાથે મદદ કરવા માટે અમુક ચોક્કસ મુદતો દ્વારા પગલાં લેવાની જરૂર પડી શકે છે. તમે કોઇ પણ ખર્ચ તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવા માટે અધિકાર છે. 1.855.315.5386 કૉલ કરો.
7. Hindi	इस सचनाम मह*वपण जानकार2 है। इस सचनाम आपक आवदन या Community Health Choice 9वारा कवरज के बार म मह*वपण जानकार2 है। इस सचना म मह*वपण तार2ख= के>लए खो◌िजय । आप अपन DवाDEयक कवरज रखन के>लए या लागत के मदद के>लए GनिHचत समय सीमासे कारवाई करना जKरत हो सकती है। आपको अपनी भाषा म इस जानकार2 और सहायता GनःशRक S◌ाTत करन का अUधकार है। 1.855.315.5386बलाइय |
8.Japanese	この通知には必要な情報が含まれています。この通知にはCommunity Health Choice の申請または補償範囲に関する重要な 情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特 定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。 1.855.315.5386までお電話ください。
9. Korean	이 통지서는 중요한 정보를 담고 있습니다. 이 통지서는 Community Health Choice를 통한 귀하의 신청이나 보험보장에 대해 중요한 정보를 담고 있습니다.. 이 통지서에서 주요 날짜를 확인하십시오. 귀하의 건강보험 보장을 유지하거나 비용 에서 도움을 받기 위해서는 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는, 이러한 정보를 받고 무료로 귀 하의 언어로 도움을 받을 권리가 있습니다. 1.855.315.5386로 연락하십시오.

10. Laotian	ຫນັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນ. ຫນັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບໃບສະຫມັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນວັນທີ່ທີ່ສໍາຄັນໃນຫນັງສືແຈ້ງການນີ້.ທ່ານອາດຈະຕ້ອງປະຕິບັດພາຍໃນກໍານົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອໃນເຣື່ອງຄ່າໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ 1.855.315.5386.
11 Persian	شاب ی‌م ی‌مهمد. این طاالح هیعلایو اکنت ی‌مهم ردابهر هماناضاقت و پوشش همیب یا ت امشوسط Community Health Choice ی‌م نم هبروظ برقرار هگنادتشن پوشش همیب یا ای ردفایت کـمک زهنی، کممن است اینز شابد لهم ات هکت های این طااح هیعلایو طااعلات هب زابن خدواتن ردفایت بیامند. امش ابهر فلتن‌امت 1.855.315.5386س شابد. ات هبرخی های ذکر شهد رد این طاات هیعلاوبیامن هجد. قم،رر اقادی‌تام ار اامجنم هدید. حق سامشت هک این طااعلات و کـمک ار بروط اراگین یگبرید.
12. Russian	Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемым Community Health Choice. Обратите внимание на основные даты, указанные в настоящем уведомлении. Возможно, будет необходимо предпринять действия до наступления конечного срока для сохранения страхового полиса или для получения помощи в оплате расходов. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону: 1.855.315.5386.
13. Spanish or Spanish Creole	Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Community Health Choice. Preste atención a las fechas clave que se incluyen en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al teléfono 1.855.315.5386.
14. Tagalog	Ang Notisyang ito ay naglalaman ng Importanteng Impormasyon. Maayroon itong importanteng impormasyon tungkol sa inyong aplikasyon o pagpapaseguro sa pamamagitan Community Health Choice. Hanapin ang mga importanteng petsa sa notisyang ito. Maaaring may kailangan kayong gawin bago ang mga itinakdang deadline para manatiling nakaseguro o para matulungan kayo sa mga kailangang babayaran. Kayo ay may karapatang makatanggap nitong impormasyon at makatanggap ng pagsasalin sa inyong wika na wala kayong babayaran. Tawagan ang 1.855.315.5386.
15. Urdu	یمں اہم لعموامت یہں سا نوٹس یمں Community Health Choice ےک رذےعی پآ یک ردخاوست فحت ےک ےمیب ایظ لعتم ےسق اہم لعموامت یہں کو دےیھکی احصہ ینپت فحت ےک ےمیب ےکظ کو برقرار رایہ ےنهک اخاراجت یمں مدد ےیلئ ےک پآ کواخ هچکص اترخینو اک کـتاوررئ سا نوٹس ےہ۔ پآ کناو لعموامت روا مدد کاوینپ زابن یمں فمت صاحل کرح اک ےنق صاحل ےہپ 1.844.515.4877ر اربهط کریں سا نوٹس یمں اہم اترخینو کرضی ک ےنترور ہوی‌تکس
16. Vietnamese	Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về mẫu đơn của bạn hoặc bảo hiểm qua chương trình Community Health Choice. Xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải thực hiện trong thời hạn nhất định để giữ bảo hiểm sức khỏe của bạn hay giúp đỡ chi phí. Bạn có quyền được thông tin này và giúp đỡ trong ngôn ngữ của bạn miễn phí. Xin gọi 1.855.315.5386.

Non-Discrimination Statement: Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Community Health Choice, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Customer Care Center at 1.855.315.5386. If you believe that Community Health Choice, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance.

If you need help filing a grievance, Pamela Hellstrom, Vice President-Corporate Compliance & Risk Management, is available to help you. You can file a grievance in person or by mail, fax, or email:

Pamela Hellstrom, Vice President-Corporate Compliance & Risk Management
2636 South Loop West, Suite 125
Houston, Texas 77054

Phone: 713.295.6704
Email: Marketplace_Grievances@communitycares.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)