Resource Guide For Addiction and Mental Health Care Consumers

Answering Questions about Insurance Coverage and Parity for Addiction and Mental Health Care Services

September 2016

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A Quick Guide to Getting Help and Coverage for Addiction and Mental Health Care Services

How Do I Get Treatment?

- ***You should have an evaluation completed by a health care professional.*** Call your doctor or other provider to confirm what addiction or mental health care services and supports you need.
- ***Be informed!*** Call the number on the back of your insurance card for addiction or mental health care services in order to find the right provider in your network.
- ***Use the treatment locator*** at www.nhtreatment.org to find someone who treats addiction or to look into treatment options.
- ***Approval for visits.*** Most health insurance companies allow two routine outpatient visits for evaluation and care of an addiction. After that, you may need approval for additional visits. Ask your provider to help you get authorization for services.

If you or someone you know is at risk or in crisis, help is available 24/7:

The New Hampshire Statewide Addiction Crisis Line
1-844-711-HELP (4357)

The National Suicide Prevention Lifeline
1-800-273-TALK (8255)

Mental Health Crisis Intervention Services are also available 24/7 by calling your local hospital or community mental health center.

What Happens If I Am Denied Treatment?

- ***Do not take "no" for an answer – you should seek help!***
- Your insurance company may decide not to pay for your addiction or mental health care services. This is called a "denial of coverage." If this happens to you, get help and ask for an appeal.
- ***Should I appeal? YES, and quickly!*** Appeals are often successful! An appeal is the process by which you (and your provider) can fight a decision by your insurance company not to pay for addiction or mental health care services. There are no fees or costs to you for an appeal!
- ***Contact your provider or the NH Insurance Department at 1-800-852-3416 for help with your appeal.***

Because of the new laws protecting access to addiction or mental health care, there is a good chance your health insurance company may approve the services you need.

If you have questions about your health insurance coverage for addiction or mental health care services, call the NH Insurance Department Consumer Hotline at 1-800-852-3416 for assistance.

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INTRODUCTION

Navigating the maze of health insurance coverage can be difficult. For individuals with addiction or mental illness, the process of getting treatment approved and paid for by health insurance can be overwhelming. As a result, many people give up when their health insurance company denies coverage for needed services. This Guide can help people learn how to access health insurance and use their coverage to pay for treatment. This Guide also provides a basic explanation of consumers' rights under the federal Mental Health Parity and Addiction Equity Act.

How do I use this Resource Guide?

This Guide is designed to help those who need addiction or mental health care services learn more about how their health insurance pays for or covers services. (This Guide uses the term ***health insurance***, to mean health plans or programs that insure, or pay for, addiction, mental health or medical care services.) This Guide provides consumers, advocates and providers with a summary of action steps and resources to help overcome coverage obstacles. The ***Helpful Hints for Providers*** section includes additional information for providers on how to assist patients with health insurance coverage for addiction or mental health care services.

This Guide will not answer every question you have about addiction or mental health care coverage. However, this Guide will provide you with a better understanding of what your health insurance policy means; what to do if your health insurance prevents you from getting (or denies you) recommended services; and who to contact if you need more help.

If you or a family member is in a medical emergency, CALL 911 or visit your health care provider immediately.

Health care is complicated, but this Guide can help. You can always ask a friend, family member or professional to help you use this Guide to make sense of your health insurance issues.

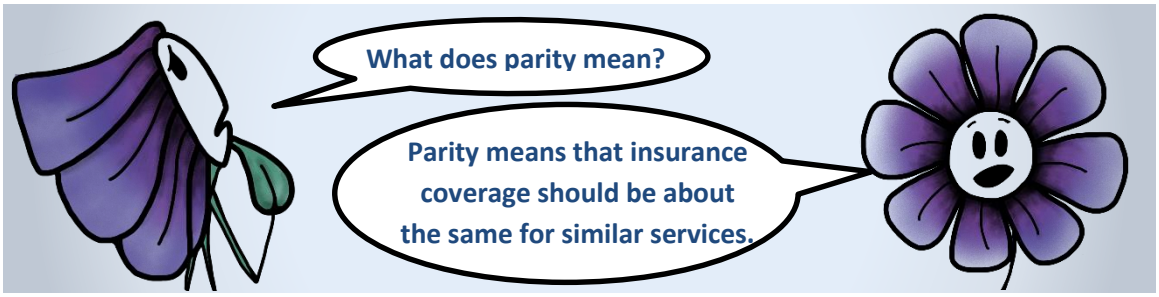
What is the Mental Health Parity and Addiction Equity Act?

Because of the Affordable Care Act (ACA), more individuals have health coverage for addiction and mental health care than ever before. Prior to the ACA, patients struggled to get equal coverage and access for addiction and mental health care services. In 2008, **The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act** (the Parity Law) made mental health and addiction parity a goal. ***Parity***, which means roughly equal coverage for addiction/mental health and physical health treatments, is now protected by state and federal law (collectively the Parity Law).

If you have questions about your health insurance, call NHID at 1-800-852-3416 or visit: https://www.nh.gov/insurance/

In New Hampshire, the Insurance Department (NHID) has a consumer representative available to help answer questions you might have about the Parity Law and your health insurance coverage. NHID may refer you to the US Department of Labor for guidance if you are part of your employer's self-funded insurance plan. More information on self-funded insurance is available under the ***Helpful Hints for Providers*** section of this Guide.

What does parity mean?



The Parity Law requires most health insurance plans to cover addiction and mental health care services in about the same way as they cover physical health care services. The Parity Law helps to ensure you can use your insurance to access the treatment you need.

Health insurance plans cannot impose greater financial requirements (such as higher copays or deductibles) or greater treatment limitations (such as visit limits) on addiction or mental health benefits than on medical benefits. Insurance practices should apply consistently to both, including:

- Copays, coinsurance and out-of-pocket maximums;
- Limits on the use of services, such as limits on the number of inpatient days or outpatient visits that are covered;
- The use of tools by the insurance company to manage care;
- Payment for services by out-of-network providers; and
- Criteria for deciding whether a service is medically necessary.

If your provider recommends addiction or mental health care services, your health insurance must allow you to access those services without unequal barriers. Parity **does not** mean that treatments for medical and addiction/mental health need to be covered in the **exact** same way. Parity **does** mean that the copays and coverage amounts should be **about** the same. For example, if your health insurance requires you to pay higher copays for addiction or mental health therapy services than for physical therapy services, or places annual limits on the number of addiction or mental health therapy visits without doing so for physical therapy, the health insurance company may be violating your rights under the Parity Law. This Guide will help explain when and how to raise questions about your rights to coverage for addiction and mental health services under the Parity Law.

Helpful hints for people seeking addiction or mental health care services

I am in crisis and need treatment immediately. What do I do?

If you, or someone you know, is in crisis **do not wait**! There is help available.

- As always, **if you are experiencing a medical emergency, call 911**.
- The **New Hampshire Statewide Addiction Crisis Line** is available 24 hours a day at **1-844-711-HELP (4357).** You can also visit the website: **http://www.dhhs.nh.gov/dcbcs/bdas/crisis-line.htm**
- The **National Suicide Prevention Lifeline** is available 24 hours a day no matter what problems you are dealing with to help you find a reason to keep living. By calling **1-800-273-TALK (8255)** you'll be connected to a skilled, trained counselor at a crisis center in your area.
- Mental health crisis intervention services are also available 24 hours a day by calling a local hospital or a community mental health center (CMHC) near you. For a list of CMHCs, visit the website: **http://www.dhhs.nh.gov/dcbcs/bbh/centers.htm**
- Reach out to a family member, friend, health professional or a peer to help you through this crisis.
- It is important for you to find a provider quickly. If you do not have a primary care doctor or other health provider, your health insurance company's consumer services representative may be able to help you find one.
- If you have questions about community services available to you, **call 211** or visit **http://www.211nh.org**
- Most health insurance companies allow two routine outpatient visits for evaluation and care of an addiction. After that, you may need approval for additional visits.

I DO NOT have health insurance. How do I access treatment?

- Go to: https://www.healthcare.gov/ or https://nheasy.nh.gov/#/ to find out your insurance options.
- Covering New Hampshire may also give you helpful information about available and affordable insurance. Visit: https://coveringnewhampshire.org/
- If you are not eligible for health insurance in New Hampshire, contact the **New Hampshire Addiction Crisis Line at 1-844-711-HELP (4357)** which can direct you to addiction treatment supported by the state.
- New Hampshire is home to many health centers that provide affordable health services regardless of income or insurance status. Find a qualified health center near you at: http://www.bistatepca.org/find-a-health-center/nh. Health centers may also have insurance navigators on staff who can help you find insurance.

I have health insurance. How do I access treatment?

- Call your primary care provider to confirm what addiction or mental health care services you need. **Your primary care provider can arrange for you to have a clinical evaluation for addiction or mental health care services.**
- **Be informed!** Find out more about the providers that are part of your insurance plan. Call the number on the back of your insurance card for addiction or mental health care treatment services to find a qualified and ***in-network*** treatment provider.
- More information about addiction treatment providers is available at the **New Hampshire Alcohol and Drug Treatment Locater** at: **http://nhtreatment.org/**. This tool can help you investigate your treatment options. Always check with your insurance company to make sure the provider you choose is in your health insurance network.
- If you are involved with the criminal justice system and have an addiction, contact the prosecutor involved in your case or your probation officer to ask about county drug courts and diversion programs. In some counties you may be able to access treatment as part of or instead of jail time.
- If you are insured through the New Hampshire Health Protection Program and believe you may be ***medically frail*** as a result of your addiction or mental illness, visit **www.nheasy.nh.gov** or call the Office of Medicaid at **1-844-275-3447**. Tell them about your condition so you get the services you need. For more information, please go to:
    - NH Medicaid: **http://www.dhhs.nh.gov/ombp/nhhpp/**
    - Service Link: **http://www.servicelink.nh.gov/**
- If you are having trouble getting a response from your insurance company, or have questions about your health insurance coverage, call the **NH Insurance Department Consumer Hotline at 1-800-852-3416** for assistance.

How can my provider help make sure my recommended care is covered?

Your health provider can be an important advocate to help you access addiction or mental health care services that are covered by your health insurance.

- **Ask your provider for help right away**. With your written consent, your health provider can contact your health insurance company to explain why you need addiction or mental health care services.

- If you are waiting for approval or have been denied services by your health insurance company, **call your provider and ask for help!** Often a provider can call your health insurance company and solve the problem!

- Your provider can help you get the insurance ***pre-authorization*** you need to start or continue treatment.

- Your provider can help you request an expedited review in an emergency!

- Your provider can help fill out the necessary paperwork for your appeal. (You can find more information about appeals on pages 8-15).

Help your provider help you! Sign a consent form to allow your provider to talk with your health insurance company about your treatment. Providers are often able to clear up any confusion about needed services.

What if my health insurance requires pre-authorization?

- Check your health insurance documents online, or call customer service to find out if you need prior approval from your health insurance company before starting treatment or services.
- If ***pre-authorization*** is required, ask your provider to help you get your services and treatments approved by your health insurance company. You will need to give written consent to your provider so he or she can contact your health insurance company.
- Your health insurance company must approve or deny your request for prescription drugs within 48 hours. New Hampshire law allows a pharmacist to provide a patient with a 72-hour emergency supply of a prescription drug.

The majority of health insurance companies allow two routine outpatient visits for evaluation and care of an addiction. After that, you may need approval for additional visits. *NH RSA 420-J:17*

As of January 1, 2017, the majority of health insurance companies must allow crisis treatment for addiction without delay by an in-network provider.

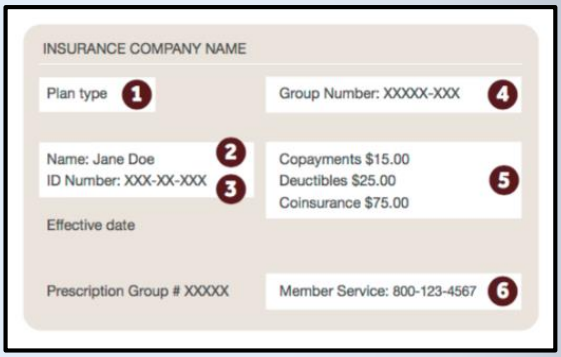
Remember, your health insurance company will probably require you to seek treatment from an in-network provider.

How can my health insurance company help?

There are two numbers on the back of most insurance cards.

- One number should be for ***Member Services***
- One number should be for ***Mental Health and Substance Use Services***

You can call either number and ask for help.



For an explanation of what these terms mean, please visit
http://nhhealthcost.nh.gov/sites/nhhealthcost.org/files/media/pdfs/insurance_card_guide2.pdf

What should I ask my insurance company?

- Ask your insurance company which providers are part of your health insurance plan. If a provider is ***in-network*** for addiction or mental health care services, your health insurance company may be able to pay the provider. **Beware!** If you receive services from an ***out-of-network*** provider, you may pay more of your own money for services.
- Ask what type of pre-authorization you need from your insurance company. If your recommended addiction or mental health care services require pre-authorization, connect your provider with your insurance company.

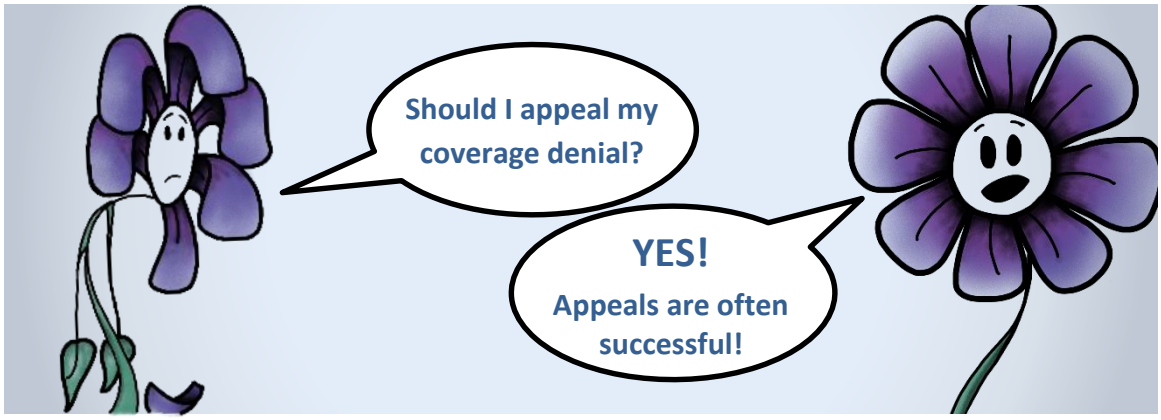
Who else can help me if I have questions or problems with my health insurance?

Call the New Hampshire Insurance Department with questions about your insurance coverage if you are having trouble getting a response from your insurance company or if you need help filing an appeal.

- **Consumer Hotline: 1-800-852-3416/ TTY/TDD 1-800-735-2964**
- **Website:** https://www.nh.gov/insurance/consumers/health.htm
- **Email:** requests@ins.nh.gov

After answering your initial questions, the New Hampshire Insurance Department will try to determine if you are in a ***fully insured*** or ***self-funded*** plan. If the number for the New Hampshire Insurance Department appears on the back of your card, you are a member of a ***fully insured*** plan regulated by New Hampshire insurance laws. If you are in a ***self-funded*** plan, you will likely be directed to the benefit advisors at the US Department of Labor. **The US DOL benefit advisors are available at 1-866-444-3272** for employees who are part of a self-funded insurance plan, or link to: https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html You may also want to contact your employer's human resources department with questions.

What should I do if my treatment is denied?



If your health insurance company denies your recommended addiction or mental health care services, you should get help! **Do not give up!**

A ***coverage denial*** occurs when an insurance company refuses to honor your claim or request to pay for addiction or mental health care services. An ***appeal*** is the process where you (or your health care provider) can challenge a coverage denial decision by your health insurance company.

Will I receive a written denial letter?

Health insurance companies in New Hampshire are **required** to send you a letter explaining why they denied your claim, and the steps to appeal their decision.

- Be sure to ask your health insurance representative to send you a copy of any denial letter if you did not receive one.
- A sample final denial letter is available for reference in the Appendix. (*See* Appendix Form 1 Sample Final Denial Letter).
- The denial letter will explain three important things:
  - Why your service was denied;
  - Who conducted the internal review; and
  - What appeal rights you have.

If you did not receive a denial letter, but you believe recommended treatment has been denied, call your health insurance company and ask for a copy of the denial letter.

What should I do if I receive a written denial letter?

- You have the legal right to challenge the denial of services by your health insurance company. **Do not take "no" for an answer if you and your provider have determined you need addiction or mental health care services.**
- You should immediately tell your provider if you received notification of a denial from your health insurance company.
- Give your provider written consent to talk to your insurance company! Your provider can explain why treatment is needed and may be able to win an approval immediately.
- Contact your health insurance company. Call the number on the back of your insurance card for customer service. Ask why they denied your claim. Customer service can also help guide you through the appeal process.
- If you are enrolled in coverage through New Hampshire Medicaid, contact your managed care company's customer service department:
    - **New Hampshire Healthy Families: 1-866-769-3085**
    - **Well Sense: 1-877-957-1300**
- **Keep track of your progress with your insurance company**. You should keep a notebook and write down the name of the person you speak to, the date of the call and the topics you discuss. Always keep copies of documents you receive from your insurance company.

What are some common reasons a claim is denied?

Health insurance companies often deny treatment for clinical reasons, such as "the treatment isn't ***medically necessary***," or for administrative reasons, such as "the service provider is out-of-network." You have a right to appeal **any** denial.

What are my options when I appeal a denial?

There are three types of appeals: ***expedited, internal, and external***.

1) An ***expedited appeal*** is used when you have an urgent need for treatment. Your insurance company must complete your expedited appeal within 72 hours of receiving your request.

2) An ***internal appeal*** is a review conducted by the insurance company over a longer period. The insurance company must decide your appeal within 30 days of your request. In general, your health insurance must provide you at least one internal appeal. You have at least 180 days to file an internal appeal from the date you received the coverage denial letter, but your insurance company sets the exact timeframe.

3) The final level of appeal is an ***external appeal.*** An external appeal is only available if your health insurance denied you treatment because it was not ***medically necessary***. You have 180 days to file an external appeal from the date of the final denial decision (in other words, the date the insurance company denied the requested treatment after all of the company's internal appeals are completed).

The ***expedited*** and ***internal*** appeals can occur at the same time, but this may not always be the best option.

If you have questions about which type appeal to file, contact the New Hampshire Insurance Department (NHID):

- **Consumer Hotline: 1-800-852-3416**
- **TTY/TDD Relay Services: 1-800-735-2964**
- **Website:** http://www.nh.gov/insurance/

What can I expect the appeals process to look like if my insurance company refuses to approve or pay for treatment?

If your insurance company refuses to pay for (or denies) a recommended treatment, you should always pursue an appeal! Many appeals are successful, resulting in overturned denials. If your need for treatment is urgent, follow instructions for an ***expedited appeal***. Otherwise, start an ***internal appeal*** with the help of your provider. If that does not work, you should pursue a more formal ***external appeal***. This Guide outlines the steps needed to start the appeal process.

Steps to Request Coverage

Step 1

Talk to your provider to determine the best treatment option. Authorize your provider to contact your insurance company on your behalf and get ***pre-authorization*** for your treatment.

Step 2

If your health insurance company will not authorize treatment, encourage your provider to intervene on your behalf. If treatment is denied, ask for a denial of coverage letter from your insurance company.

If you receive a denial letter…

Step 3

File an ***internal appeal*** with your insurance company. If your need for treatment is urgent, follow instructions for an ***expedited appeal***.

If you receive a FINAL denial letter…

Step 4

File an ***external appeal*** with the New Hampshire Insurance Department.

What is an expedited appeal?

I think my claim is URGENT, what should I do? You should ask for an expedited appeal process.

If waiting for treatment will cause you significant harm, you should ask for an **expedited review** of your claim so that you receive a final decision within 72 hours.

Talk to your provider right away about your need for URGENT treatment. If you believe a delay in services would seriously jeopardize your life or health, ask your provider to help you with an expedited appeal. For your appeal to be expedited, your provider must **certify** that your need for treatment is urgent. (*See* Appendix Form 5 **Provider Certification Form for Expedited Review**).

Expedited appeal for urgent cases must be resolved as soon as possible, **but never longer than 72 hours**. This means your insurance company must approve or deny your requested addiction or mental health care services within 72 hours of your request. If your case involves ongoing urgent treatment, your health insurance will continue to pay for your treatment until the review is complete.

What is an internal appeal?

If your health insurance company refuses to pay a claim or ends your coverage, the company must provide you with an ***internal appeal*** if requested.

- Your health insurance may tell you that your services were denied for the following reasons: (1) because the services were not ***medically necessary*** according to the health insurance company; or (2) because the type of services requested were not an appropriate level of care or in an appropriate health care setting.
- If you ask for an internal appeal, your health insurance company must conduct a full and fair review of its decision.
- This type of ***internal*** review is available **for all** treatment denials. The person reviewing the decision will not be the same person who initially denied you.

Authorize your provider to contact your health insurance company directly during an internal appeal process. Reach out and send your provider any information about your health insurance he or she requests.

- An internal appeal is easy. You can begin your internal appeal process by calling or writing a letter to your health insurance company. Be sure to include information about your health insurance, the services recommended for you and information about how to reach your provider.
- A sample internal appeal request is available in the Appendix. (*See* Appendix Form 2 Sample Internal Appeal Request).

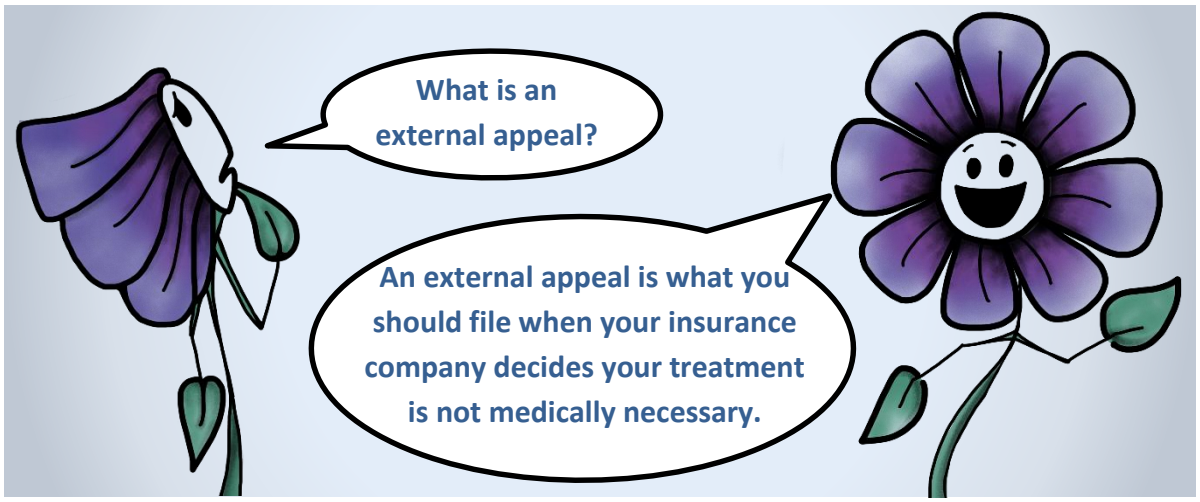
When should I receive a response from my health insurance company on my internal appeal?

- Generally, you should receive a response from your health insurance company within **30 days** of the date you filed your first appeal.
- If your health insurance company provides two levels of appeal, the first level will be complete within **15 days** and the second within **30 days** of the date of your first appeal.

What is an external appeal?

The ***external appeal*** is one of the final steps in the appeals process.

- If your health insurance company denies your services because they are not ***medically necessary***, you can file an ***external appeal***.
- You have a right to an independent third party review of the denial. The independent reviewer will decide whether your health insurance company properly denied your services.
- Instructions for filing an ***external appeal*** are available in the Appendix. (*See* Appendix Form 3 External Review Application Instructions) and online at https://www.nh.gov/insurance/consumers/appeals.htm



How do I file an external appeal?

- You have **180 days to file an appeal** once you receive a final denial decision, but do not wait! You should file your appeal as soon as possible. Acting quickly can prevent unnecessary delays in your treatment.
- **External Appeal Forms**: The forms you will need to file an external appeal are provided in the Appendix. (*See* Appendix Form 3 **External Review Application Instructions** and Form 4 **External Review Application Form**). These forms are also available on the New Hampshire Insurance Department website: **https://www.nh.gov/insurance/consumers/documents/ex_rev_app.pdf**
- **Submit documents and records with your appeal**: You should submit any documents and medical records supporting your need for services with your appeal. You can submit documents **even if** your health insurance did not have them when making its initial denial.
- **Ask for documents from your health insurance company**: You may request copies of any information your health insurance considered when making its initial denial. If you make this request, your health insurance must provide the information to you.
- **Seek input from your provider**: Your provider will be important in your appeal. With your written consent, your provider may discuss your case with your health insurance company or the independent reviewer. Your provider should provide a statement explaining why the recommended treatment is medically necessary. There is a special place on your appeal form (Section V) for your provider's information. (*See* Appendix Form 5 **Provider Certification Form**).
- **Get help from a friend**: A friend or a loved one can help you work with your health insurance company. Ask if you can designate someone to act as your personal representative. You will have to sign a written consent form. Your selected representative can talk with your insurance company for you and can also help with your appeal by writing letters of support for your treatment.

I am enrolled in Medicaid. Do I have any additional rights?

Yes. If you are enrolled in Medicaid, you may be able to access the Medicaid Fair Hearing process to pursue a further appeal. Call the Department of Health and Human Services (DHHS) at **1-844-275-3447** or go to: www.dhhs.nh.gov/oos/aau for more information or to get a Medicaid Fair Hearing form.

What happens if I make a mistake when I submit my appeal information?

If you forgot to submit necessary information with your appeal, **do not worry!** Provide the corrected information as soon as you can. Your insurance company may also ask you to submit additional information. Respond to the request and provide the information quickly, asking for help if you need it.

What if my insurance company denies my treatment as not being medically necessary?

- Always ask your health insurance company why your claim has been denied. Health insurance companies often deny claims because they are not ***medically necessary***.
- Ask your insurance company for an explanation of its decision. The reason for the denial **must be included** in the denial letter you receive from your health insurance company.
- Medical necessity refers to care that is reasonable, necessary or appropriate based on current standards of care. This means the services are necessary for the treatment of a medical condition.
- Each insurance company sets its own standards for determining if a treatment is medically necessary. Your policy will include the definition in writing.
- Ask your health insurance company for its definition of ***medical necessity***. Be sure to discuss the definition with your provider.

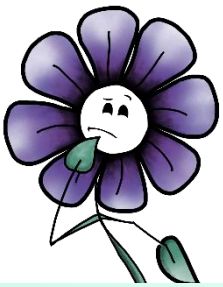
Always ask your health insurance company why your claim has been denied.

I have been hearing about insurance parity for a long time. Why is there such a focus on it now?

The Parity Law has been in place since 2008. However, the Parity Law does not actually require health insurance companies to include addiction and mental health care benefits. As a result, many health insurance companies were not paying for addiction and mental health care services.

This problem was addressed by the Affordable Care Act (ACA). Under the ACA, insurance coverage in the individual and small group markets must include the "10 essential health benefits." These benefits include addiction and mental health care services. Because most health insurance now covers addiction and mental health care services, ***parity*** now applies. As of July 1, 2016, the Parity Law applies (with few exceptions) to all employer group insurances and individual insurance.

How does the Parity Law protect me?



Health insurance companies must not impose more restrictive treatment limitations on addiction or mental health care services.

Below are a few examples of parity violations:

Insufficient benefits: Health insurance does not allow out-of-network providers, or offer inpatient services to treat addiction or mental health patients even though these services are available for medical patients.

Higher financial requirements: Health insurance charges higher copays to patients seeing addiction or mental health care providers than patients seeing medical providers.

More restrictive Quantitative Treatment Limitations (QTLs): Health insurance places visit limits on addiction or mental health treatments that are more restrictive than the limits for medical visits.

More restrictive Non-Quantitative Treatment Limitations (NQTLs):
(1) health insurance has pre-authorization requirements for many addiction or mental health treatments, but few medical treatments have the same restrictions; or
(2) health insurance requires written treatment plans for addiction or mental health care services, but not for medical treatments.

Lower annual dollar limits on benefits: Health insurance has annual dollar limits on addiction or mental health benefits, but not for medical benefits.

Inadequate disclosures: Health insurance does not reveal how "medical necessity" is determined or the reason for the benefit denial.

I have questions about my health insurance company's compliance with the Parity Law?

The New Hampshire Insurance Department reviews all health insurance plans offered in the state to make sure their coverage complies with the Parity Law.

Unfortunately, health insurance companies do not always make decisions that seem fair.

If you are appealing a coverage denial, you may explain the reasons you believe the denial is unfair or seems like a parity violation in your appeal documents.

If you have questions or concerns about parity as it applies to your own care or a claim denial, please contact the New Hampshire Insurance Department Consumer Services Division at 1-800-852-3416.

Helpful hints for providers of addiction or mental health care services

I am a provider of addiction or mental health care services. How can I help my patients access coverage?

Review this Guide and make it available to your patients!

- Tell your patient that you can be an advocate.
- Be prepared to contact your patient's health insurance company and explain the medical necessity for services. Do not exaggerate. Be clear in the diagnosis and the reasons for the recommended treatment.
- Encourage your patient to execute a consent form authorizing you, as a provider, to contact the health insurance company to help coordinate addiction or mental health care and coverage.
- Often, initial coverage denials can be overturned if a provider contacts the health insurance company directly to clear up misunderstandings around the need for treatment or services.
- Help your patient obtain the appropriate pre-authorizations by communicating with your patient's health insurance company.
- As a provider, your certifying the need for treatment or services is essential to your patient's success in appealing a coverage denial. (*See* Appendix Form 5 **Provider Certification Form**).
- Provide your patient the contact information for the **New Hampshire Insurance Department Consumer Hotline 1-800-852-3416**.
- Show your patient the phone numbers on his or her insurance card, including the number for ***member services*** and ***addiction*** or ***substance use disorder*** services, and explain the information on the card.
- Help your patient appeal a coverage denial decision by the health insurance company if you have recommended addiction or mental health care services.

What does insurance parity mean for providers?

Addiction and mental health care services haven't always been covered by insurance. Why now?

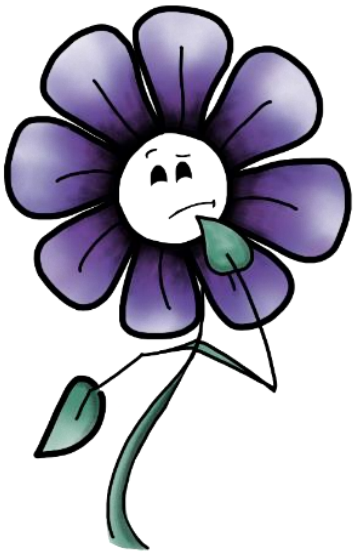
Under the Affordable Care Act (ACA), addiction and mental health care services are one of the ***essential health benefits*** that must be covered by ACA-compliant health insurance in the individual and small group markets. In New Hampshire, most insurance includes addiction and mental health coverage and must comply with requirements for parity between medical and addiction/mental health coverage.

The final rules about mental health parity now apply to health insurance plans. New ***parity*** rules require Medicaid managed care organizations to comply by October 2017.

The New Hampshire Insurance Department has the authority to enforce parity obligations with regard to health insurance offered by regulated health insurance companies in New Hampshire.

How can I identify a potential parity violation?

The Parity Law requires most health insurance plans to provide mental health and addiction treatment benefits that are at least as generous as the benefits for medical treatment. The comparison is not exact, but instead is based on a ***two-thirds*** test. The treatment limits or financial requirements placed on addiction or mental health care services can't be more burdensome than the requirements applied to two thirds of the same type of medical services.



For example, if a health insurance plan applies a $50 copayment to outpatient medical services by in-network providers at least two-thirds of the time, an insurer can charge a $50 copayment for all outpatient mental health services that are provided in-network as well.

The Parity Law compares addiction or mental health care services to medical services in the following classifications: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) emergency care, and (6) prescription drugs.

The Parity Law prohibits ***medical management techniques*** such as restricting treatments to a certain location, facility type or provider specialty unless such techniques are imposed comparably to medical benefits. For example, insurance companies can't require a mental health or addiction patient to use an in-state provider if it allows medical patients to use out-of-state providers.

While health insurance companies look at a variety of factors to decide provider rates (e.g., service type, demand for services, supply, practice size, Medicare rates, training and experience, etc.), the factors they use must be applied equally to both addiction/mental health providers and medical providers.

The Parity Law provides useful examples of common fact patterns which raise parity issues. Refer to the links in the ***Additional Resources*** section for details on parity rules.

The Parity Law can be difficult to understand in practice, which is why the New Hampshire Insurance Department (NHID) is reviewing health insurance plans and activities for compliance. Call the NHID if you have questions or concerns at 1-800-852-3416.

Does it matter what type of plan my patient is enrolled in? Fully insured v. self-funded?

If your patient has group health insurance through an employer, the patient may be enrolled in a ***fully insured*** plan or a ***self-funded*** plan. It's important to advocate for your patient's treatment needs no matter what type of coverage your patient has.

The differences between fully insured and self-funded health insurance plans may not be immediately apparent. The plans are regulated by two different government entities: The New Hampshire Insurance Department (NHID) regulates ***fully insured*** plans while the U.S. Department of Labor regulates ***self-funded*** plans.

Call the New Hampshire Insurance Department consumer phone line with questions or concerns about whether coverage is *fully insured* or *self-funded*, or other questions about a particular patient's coverage 1-800-852-3416.

You must first ask your patients to authorize you to communicate on their behalf.

Fully insured plans are those for which an employer pays a fixed monthly premium for an employee's participation. ***Self-funded*** plans are offered by employers or unions who directly assume the major cost of the health services for their employees or members. ***Self-funded*** plans almost always hire a claims administrator – typically a licensed insurance company— to administer the benefits, so the insurance card for a self-funded plan may look very similar to the card for a fully insured plan.

The type of insurance plan a patient is enrolled in can be found on his or her insurance card. If the New Hampshire Insurance Department phone number is on the back of the card, the patient is enrolled in a ***fully insured*** plan regulated by the NHID.

Glossary: What insurance terms should I know? What do they mean?

Addiction and Mental Health: The study of emotions, behaviors and biology relating to a person's mental well-being. It includes the assessment, diagnosis, treatment and prevention of medical illness and addiction/substance use disorders.

Appeal/Appealing a Claim/Appeal Process: The process by which you (or your healthcare provider) can fight a denied insurance claim or termination of your requested services. There are no fees or costs related to the appeals process.

Carrier: The health care service plan or health insurance company that issues your health insurance coverage.

Claim: A formal request to an insurance company asking for a payment based on the terms of the insurance policy. Insurance claims are reviewed by the company (health insurance or health plan) to determine whether the services are covered and whether the health insurance will pay for the services.

Classifications of Benefits: There are 6 categories of benefits within which all mental health and addiction services must be classified: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) emergency care, and (6) prescription drugs.

Copayment: A fixed amount you pay for a health care service, usually at the time you receive the service.

Deductible: A specific dollar amount that insured individuals must pay out-of-pocket before the insurance company will make payments. You can call the number on the back of your insurance card to find out your deductible.

Denied Medical Claim: When an insurance company refuses to grant an individual's request for payment of health care services.

Employee Assistance Programs (EAPs): Mental health and addiction counseling services that are sometimes offered by health insurance or employers. EAPs are intended to help employees deal with personal problems that might adversely impact their job performance, health, and well-being.

Exclusions: Specific conditions, services, or treatments listed in your insurance documents for which health insurance will not provide coverage.

Explanation of Benefits: A statement the health insurance company provides which lists services billed by providers, how charges were processed, and how much a patient will need to pay.

External Review: This is the final step in the appeals process. If you are not satisfied with the results of your internal appeal, you have the right to request an independent third party review. The third party will review the documentation to determine whether the insurance company should pay for the treatment.

Fail First Protocol: A strategy used to reduce health care costs. An insurance company will only pay for a more expensive treatment if a less expensive option fails. For example, an individual might be prescribed a generic medication before coverage of a brand name medication is provided.

Financial Requirements: Financial requirements for the patient include deductibles, copayments, coinsurance, and other out-of-pocket expenses.

Fully Insured Plans: Your employer pays a fixed monthly premium (amount) for you and your family's participation.

Generic Drug: A prescription drug that is comparable to a brand name prescription drug in dosage form, strength, quality, performance characteristics, and intended use. Generic drugs are usually less expensive than brand name drugs.

Health Insurance Plan: An insurance plan secured by individuals or groups that provides coverage and payment for health benefits. Licensed insurance companies, unions, and self-insured employer groups with the assistance of third party administrators offer health insurance.

Health Insurance Portability and Accountability Act (HIPAA): Provides privacy standards to protect patients' medical information provided to health insurance, doctors, hospitals and other health care providers.

In-Network: A set of providers and facilities that provide care under an insurance policy at a discounted rate. For some types of plans, services (other than emergency services) are covered only if you use an in-network provider, so it is important to check with your insurance company to see whether a provider is in-network for you before seeking care.

Inpatient: Services delivered in a hospital for at least 24 hours.

Medicaid: A program operated jointly by the state and federal governments to provide health coverage for qualifying low-income individuals or families. New Hampshire Medicaid includes coverage through Medicaid Managed Care organizations (as of 2016, Well Sense and NH Health Families) and the New Hampshire Health Protection Premium Assistance Program (NHHP PAP), which purchases private health insurance coverage for certain Medicaid eligible enrollees. Your health insurance card should identify which type of coverage you have. Call the number on your card to ensure you have access to needed health care services through the Medicaid program.

Medicare: A federal health insurance program for people over 65 and people with certain disabilities who are younger than 65.

Medically Necessary/Medical Necessity: Criteria health insurance companies use to determine if health care services should be covered. A medical service generally meets medical necessity criteria when it is consistent with general medical care standards, a patient's diagnosis, and the least expensive option available.

Out of Network/Out of Plan: These are providers not listed by an insurance policy. Costs may not be covered or may cost more out-of-pocket than an In-Network provider's costs.

Outpatient Care: Any care or treatment that does not require an overnight stay in a hospital or similar treatment facility.

Parity: Similar costs and benefits for mental health/addiction and medical treatments. The costs and benefits do not have to be exactly equal to meet parity standards– just similar.

Pre-Authorization/Prior Authorization/Prior Approval/Pre-Certification: When health insurance companies decide that certain services, treatment plans, and medications are "medically necessary" before coverage will be granted.

Pre-Existing Condition: A medical condition that existed prior to obtaining an insurance policy from a specific company. Having a pre-existing condition no longer changes treatment options or coverage for that condition.

Preferred Provider Organization: A managed care organization that provides discounts to the health care provider on treatment options.

Self-Funded Plan: Governed by the **Employee Retirement Income Security Act of 1974 (ERISA)** and regulated by the **Department of Labor**; a plan offered by employers or unions who pay the major cost of health services for their employees or members.

Small Group: Employer-based insurance plans with less than 50 enrolled employees.

State-Mandated Benefits: Specific benefits a health insurance company must offer under state law.

Additional resources

Mental Health Parity and Addiction Equity Resources

- New Hampshire Department of Insurance Resources: http://www.nh.gov/insurance/consumers/sud-exam-preliminary-findings.htm
- The Kennedy Forum Parity Resource Guide for Addiction & Mental Health Consumers, Providers, and Advocates: http://www.thenationalcouncil.org/capitol-connector/wp-content/blogs.dir/2/files/2015/08/Parity-Appeal-Guide-Winter-2015.pdf
- Legal Action Center, A Guide to the Federal Parity Law: http://lac.org/parity-guide-explains-right-to-health-insurance-coverage-for-addiction-mental-health-care/
- Community Catalyst Resources: http://www.communitycatalyst.org/resources/publications/document/Parity-Basics-FINAL.pdf
- The American Psychiatric Association Mental Health Parity Poster: https://www.psychiatry.org/psychiatrists/practice/parity
- The American Psychological Association Parity Guide Information: http://www.apa.org/helpcenter/parity-law-resources.aspx

Federal Government Resources

- SAMHSA Mental Health Parity page: http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- US Department of Labor: Mental Health Parity page: https://www.dol.gov/ebsa/mentalhealthparity/

New Hampshire Resources

Questions about Insurance

- The New Hampshire Insurance Department has a consumer line available to take your calls: **Consumer Hotline: 1-800-852-3416/TTY/TDD Relay Services 1-800-735-2964**
- If you have insurance, call the number for member services or for mental health/addiction services listed on the back of your insurance card.
- If you are enrolled in coverage through New Hampshire Medicaid, contact your managed care company's customer service department.
    - **New Hampshire Healthy Families: 1-866-769-3085**
    - **Well Sense: 1-877-957-1300**

Questions about Addiction or Mental Health Care Services

- **The New Hampshire Statewide Addiction Crisis Line is available 24/7 at 1-844-711-HELP (4357**). You can also visit the website: http://www.dhhs.nh.gov/dcbcs/bdas/crisis-line.htm
  The National Suicide Prevention Lifeline is available 24/7 at 1-800-274-TALK (8255).
- Mental health crisis intervention services are also available 24 hours a day by calling your local hospital or a community mental health center (CMHC) near you. For a list of CMHCs, visit the website: http://www.dhhs.nh.gov/dcbcs/bbh/centers.htm
- Find a qualified health center near you at: http://www.bistatepca.org/find-a-health-center/nh
- If you have questions about community services available to you, call 211 or visit: http://www.211nh.org

NH Department of Health and Human Services Resources

- NH Bureau of Drug and Alcohol Services: http://www.dhhs.nh.gov/dcbcs/bdas/index.htm
- Drug Free NH: http://drugfreenh.org/
- Bureau of Behavioral Health: http://www.dhhs.nh.gov/dcbcs/bbh/index.htm
- Service Links: http://www.servicelink.nh.gov/

NH Insurance Department Guidance for Consumers on Appeals

- General Appeals Information: https://www.nh.gov/insurance/consumers/appeals.htm
- Consumer Guide to External Appeal: https://www.nh.gov/insurance/consumers/documents/ex_rev_guide.pdf
- Independent External Review: https://www.nh.gov/insurance/consumers/documents/ex_rev_app.pdf

NH Managed Care Laws

- Grievance Procedures: http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5.htm
- Right to External Review: http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-a.htm
- Standard External Review: http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-b.htm
- Expedited External Review: http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-c.htm
- Certification of Independent Review Organizations: http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-d.htm
- General Provisions Regarding External Review: http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-e.htm

Appendix

Form 1: Sample Final Denial Letter

Form 2: Sample Internal Appeal Request Letter

Form 3: External Review Application Instructions

Form 4: External Review Application Form

Form 5: Provider Certification Form for Expedited Review

Form 1: Sample Final Denial Letter

Company Letterhead
Company Name
Mailing Address
City, State, Zip Code

Company Logo

Date

Insured Member's Name
Address
City, State, Zip Code

Member/Patient Name:
Insurance Plan Number:
Claim/Case Number:

Dear **Member Name**:

Insurance Company Name has finished reviewing your appeal for **Substance Abuse Subacute/RTC Rehabilitation level of care** at **Name of Treatment Facility**. Coverage for the requested services remains denied, because **they are not considered medically necessary**.

This case was reviewed by **Name of Medical Provider, including a description of his/her credentials** .

Based on the medical records given to us by **Name of Treatment Facility**, your doctor wanted you to receive **inpatient treatment for Substance Use Disorder (SUD)**. We do not believe this level of treatment is medically necessary, because **studies show outpatient treatment is appropriate for you condition**.

This is our final decision. Your internal appeal rights are exhausted. We've included details with this letter. If you have any questions about this letter, please call customer service at the phone number on your ID card.

What other rights do I have?
You may be eligible to have this decision reviewed by a nationally accredited, independent, medical review …

You have 180 days from the date of this letter to ask for an external appeal. If you need help or have any questions about external appeal, you may call the Insurance Department at 1-800-852-3416 and speak with a consumer services officer.

Other helpful resources:
You may contact the New Hampshire Department of Insurance for assistance at any time.

Address: New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
Phone: 1-800-852-3416
Email: consumerservices@ins.nh.gov
Online: www.nh.gov/insurance

Form 2: Sample Internal Appeal Request Letter

FORM 2: SAMPLE INTERNAL APPEAL REQUEST

For use as an internal appeal request directly to your insurance company. This is not a substitute for the External Appeal Application included as Form 3.

Date

Insured Member's Name
Address
City, State [Zip Code]

Patient/Member Name:
Insurance Plan and Number:

Re. Appeal for [type of treatment] requested

To Whom It May Concern:

I am a member of [HEALTH PLAN NAME] and I am writing to appeal your decision to deny coverage for [**state the name of the treatment[s] or service[s] denied**].

It is my understanding based on your communication [**by letter/phone/email**] on [**date of denial**] that you denied the treatment because [**state the reasons given for the denial of coverage or state that no reasons were given**].

My provider [**name of provider**] is a qualified [**type of provider**] and recommends [**the treatment/service**] as treatment for me. [**Provide any details about the need for treatment you feel comfortable providing]**.

[**Attach a letter from your provider explaining when and why the provider recommends the treatment/service or summarize the reasons the treatment/service has been recommended. If you do not have a letter, ask your provider to contact your insurance company**].

[State whether or not your need for services is URGENT to prevent harm to you].

Please provide me with a release form immediately so that my provider and I can communicate directly with you about my treatment needs. Please also provide me with:

1) A complete explanation of why services/treatments have been denied and why
2) A copy of my summary plan description including any descriptions for mental health or substance use disorder services coverage;
3) Please identify any specific provisions that support your denial of treatment
4) Please explain what steps I should take and any time periods that apply in order for me to be sure my appeal is promptly addressed.

Thank you. If you have any questions or need any documents or information, please contact me both by email and by phone as follows:

Phone
Email
Sincerely, [NAME]

Resource Guide

Form 3: External Review Application Instructions

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The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

INDEPENDENT EXTERNAL REVIEW

Appealing a Denied Medical or Dental Claim

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's Consumer Guide to External Review, available at www.nh.gov/insurance, or call 800-852-3416 to speak with a Consumer Services Officer.

Have a question or need assistance?

Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.

SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

☐ The enclosed, completed application form - signed and dated on page 6.

**** The Department cannot process this application without the required signature(s) ****

☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.

☐ A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.

☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.

☐ If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review applications may be faxed to (603) 271-1406 or sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.

Form 4: External Review Application Form

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name:_____ Patient's Date of Birth: _____

Applicant's Name:_____ Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____

City: _____State: _____ Zip Code: _____

Representative's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes ____ No ____

- Name of employer: _____
- Employer's Phone Number: **(_____) _____**
- Is the employer's insurance plan self-funded? Yes* ____ No ____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes ____ No ____

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: _____

I, _____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PCP's Phone Number: (_____) _____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider's Phone Number: (_____) _____

Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

_____

_____

_____

_____

_____

_____

_____

_____

Continued on next page

Section VI – Expedited Review

** Complete this section, only if you would like to request expedited review **

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes ____ No ____

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes ____ No ____

My reason for requesting a phone conference is:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

VIII – Authorization and Release of Medical Records

I, _____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

Sign Here

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

---

Before submitting this application, please verify that you have …

☐ Completed all relevant sections of the External Review Application Form
- If appointing an authorized representative, the patient must complete Section II.
- If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
- If requesting a telephone conference, Section VII must be completed.

☐ Signed and dated the External Review Application Form in Section VIII.

☐ Attached the following documents:
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

Resource Guide

Form 5: Provider Certification Form for Expedited Review

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (_____) _____.

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date

Notes

Notes