Health Benefits Appeal Request For External Review

Mid-America Carpenters Regional Council Health Fund (Fund)
Northern Illinois Region
12 E. Erie St, Chicago, IL 60611
Phone: (312) 787-9455 | Fax: (312) 951-1515 | Email: submit@macbenefits.org

If an appealed health benefit claim involving a medical judgment, the balance billing protections of the No Surprises Act, or rescission claim is denied by the Board of Trustees Appeals Committee or a third party claims fiduciary, the Claimant may request further external review by an independent review organization (IRO). Claims denied due to failure to meet the requirements for eligibility and/or enrollment under the terms of the Plan are **not** eligible for external review.

REQUIREMENTS TO REQUEST AN EXTERNAL REVIEW. Both requirements must be met to file an appeal.

1. **Right to External Review.** The Board of Trustees **Appeals Committee or third party claims fiduciary appeal process must have maintained denial of a claim**, in whole or in part, via the *Adverse Benefit Determination Appeals* process as outlined in the Summary Plan Description. You may only request an external review after you have exhausted the internal review and appeals process.
2. **Timeliness.** Requests for External Review must be filed **no more than 4 months** after receipt of the appeal denial letter from the Appeals Committee **or third party claims fiduciary, as applicable**.

EXPEDITED (URGENT) EXTERNAL REVIEW — NARROW CRITERIA, READ CAREFULLY

Expedited review is available **only** if your situation meets one of these two specific standards under the Plan. This is a narrow medical standard, not a matter of preference or inconvenience. Supporting documentation is required to process an expedited request. For Box 1, attach a signed statement from your physician establishing the urgency described above. For Box 2, attach documentation confirming your current inpatient or emergency status (e.g., hospital admission verification).

1. ☐ A physician has indicated that waiting for the standard external review timeframe would seriously jeopardize your life, your health, or your ability to regain maximum function.
2. ☐ You are currently hospitalized, receiving emergency care, or in a continued inpatient stay, and have not yet been discharged.

If your situation meets one of these two criteria, call us immediately so we can watch for your form and begin review right away. **The Fund determines whether a request qualifies as expedited based on these Plan criteria, not based on the claimant's own assessment of urgency.** Requests that don't meet the standard or that are submitted without supporting documentation will be processed under the standard timeline described under "What Happens Next" below, regardless of how the box is checked.

Original Appeal regarding (check one): ☐ Premium Plan of Benefits ☐ Basic Plan of Benefits

SECTION 1: CLAIMANT INFORMATION *Individual requesting the external review.*

Claimant is: ☐ Participant/Carpenter ☐ Surviving Spouse ☐ Patient ☐ Authorized Personal Representative*

** Submission of completed and signed Fund Office Authorized Personal Representative Designation Form is required.*

Claimant Legal Last Name	Claimant Legal First Name	Claimant Legal Middle Name	Last 4 Digits of SSN

Mailing Address	City	Zip Code

Appellant Preferred Phone Number	Email Address

SECTION 2: PARTICIPANT/CARPENTER INFORMATION *Skip this section if the same as section 1.*

Participant Legal Last Name	Participant Legal First Name	Participant Legal Middle Name	Participant UID

Mailing Address	City	Zip Code

Participant Preferred Phone Number	Email Address

SECTION 3: EXTERNAL REVIEW REQUEST			
☐ **Check here if you are including new information regarding your claim and submit it with this form.**	Write the participant last name and last 4 digits of their SSN on every page of new information.		
I am requesting an external review of the following denied appeal:			
Claim Number(s) *see Explanation of Benefits*	Date(s) of Service	Name of Provider(s)	
Patient is: ☐ Participant/Carpenter ☐ Spouse ☐ Dependent Child			
Patient Legal Last Name	Patient Legal First Name	Patient Legal Middle Name	Date of Birth
Mailing Address (*only need to complete not already provided in Sections 1 or 2_*	City		Zip Code

SECTION 4: SIGNATURE

I declare that the information, statements, and documentation I have provided in regard to this appeal are true and complete to the best of my knowledge and belief. I understand that making false statements and/or furnishing false information will disqualify my case.

X _____ _____

Signature of Requestor Date

Submit your completed, signed form and all supporting documentation via the method most convenient for you:
• **By mail to** 12 E. Erie, St., Chicago, IL 60611 • **By email** to submit@macbenefits.org • **By fax** to (312) 951-1515

What Happens Next?

- **Expedited Review:** The preliminary review, notice of eligibility, and IRO assignment described below will all occur immediately rather than on the standard timeline. The assigned IRO will provide a decision within 72 hours of receiving the request. If that decision is not provided in writing, the IRO will provide written confirmation within 48 hours after delivering the decision.
- **Standard Review:** Within five (5) business days of the receipt of your request for an external review by the Plan, the Plan will complete a preliminary review to determine whether your claim is eligible for an external review. Within one (1) business day of completing the preliminary review, the Plan will notify you in writing as to whether your application meets the requirements for an external review. If the request is complete and eligible, the Plan will assign the request to an Independent Review Organization (IRO). Once the claim is assigned to an IRO, the assigned IRO will notify you timely in writing of the request's eligibility and acceptance for external review, including instructions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days). Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination; it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.