

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH**

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 29.	External Review Regulations [NEW]
365:10-29-1.	Purpose [NEW]
365:10-29-2.	Applicability and Scope [NEW]
365:10-29-3.	Definitions [NEW]
365:10-29-4.	Notice of Right to an External Review and External Review Procedures [NEW]
365:10-29-5.	Authorization to Disclose Protected Health Information [NEW]
365:10-29-6.	External Review Requests [NEW]
365:10-29-7.	Notice of Initiation Determination [NEW]
365:10-29-8.	Independent Review Organization Application [NEW]
365:10-29-9.	Independent Review Organization Recordkeeping and Reporting Requirements [NEW]
365:10-29-10.	Health Carrier Recordkeeping and Reporting Requirements [NEW]
Appendix PP	Notice of Appeal Rights [NEW]
Appendix QQ	External Review Request Form [NEW]
Appendix RR	Application for Registration as an Independent Review Organization [NEW]
Appendix SS	Independent Review Organization External Review Annual Report Form [NEW]
Appendix TT	Health Carrier External Review Annual Report Form [NEW]

AUTHORITY:

Insurance Commissioner; 36 O.S. §§ 307.1, 36 O.S. § 6475.5(A)(3), 36 O.S. § 6475.6(A)(2), 36 O.S. § 6475.12(G)

DATES:

Adoption:

September 9, 2011

Effective:

Immediately upon approval by the Governor

Expiration:

Effective through July 14, 2012, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY RULES:

n/a

INCORPORATION BY REFERENCE:

n/a

FINDING OF EMERGENCY:

A compelling public interest requires emergency rules due to House Bill 2072 enacted during the 2011 legislative session. House Bill 2072 created a new section of law codified as 36 O.S. § 6475 et seq., entitled the “Uniform Health Carrier External Review Act”. The Act mandates the Insurance Commissioner to promulgate rules to implement uniform standards for the establishment and maintenance of external procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in the Act.

ANALYSIS:

The new Subchapter 29 creates rules for the implementation and regulation of the Uniform Health Carrier External Review Act. 365:10-29-1 sets forth the purpose of new subchapter 29. 365:10-29-2 sets forth the applicability and scope of subchapter 29. 365:10-29-3 sets forth that all terms used in subchapter 29 shall have the same meaning as defined in 36 O.S. § 6475.4(B). 365:10-29-4 provides for the manner a health carrier shall provide notice as set out in the Notice of Appeal Rights form in Appendix PP. 365:10-29-5 requires that health carriers providing notice shall provide a form authorizing the health care provider to disclose protected health information as set out in the Oklahoma State Department of Health Standard Authorization form, ODH 206, or in the alternative, a form that complies with 45 CFR § 164.508 and 43A O.S. § 1-109. 365:10-29-6 provides for the manner a covered person or authorized representative shall request an external review as set out in the External Review Request form in Appendix QQ. 365:10-29-7 provides that a notice of initial determination shall be made in writing to the same address as the External Review Request form in Appendix QQ. 365:10-29-8 provides that an independent review organization certified by the Oklahoma State Department of Health to do external review as of August 25, 2011, may apply one time before December 31, 2011, for temporary approval effective for 180 days and sets out the necessary information required to be submitted for the temporary application. It also references the Application for Registration as an Independent Review Organization form in Appendix RR as the application to be otherwise used by independent review organizations seeking approval to conduct external reviews. 365:10-29-9 relates to the recordkeeping and reporting requirements that each independent review organization shall follow as set out in the Independent Review Organization External Review Annual Report form in Appendix SS. 365:10-29-10 relates to the recordkeeping and reporting requirements each health carrier shall follow as set out in the Health Carrier External Review Annual Report form in Appendix TT.

CONTACT PERSON:

Julie Meaders, Oklahoma Insurance Department, (405) 521-2746

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S. SECTION 253(D):

SUBCHAPTER 29. EXTERNAL REVIEW REGULATIONS

365:10-29-1. Purpose

The purpose of this subchapter is to set forth rules regarding external review regulations as authorized by the Uniform Health Carrier External Review Act ('the Act'), 36 O.S. § 6475 et seq. The general purposes of the Act and this Subchapter are to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in the Act.

365:10-29-2. Applicability and scope

This Subchapter shall apply to all health carriers, except as excluded from the Act by 36 O.S. § 6475.4(B).

365:10-29-3. Definitions

For the purpose of this Subchapter, all terms shall have the meanings set forth in 36 O.S. § 6475.3.

365:10-29-4. Notice of right to an external review and external review procedures

A health carrier providing notification of the right of a covered person to request an external review pursuant to 36 O.S. § 6475.5(A) shall provide the notice as set out in Appendix PP.

365:10-29-5. Authorization to disclose protected health information

A health carrier providing an authorization form to a covered person regarding the disclosure of protected health information pursuant to 36 O.S. § 6475.5(B)(3) shall either provide the form as set out in the Oklahoma State Department of Health Standard Authorization, ODH 206, which may be accessed at [www.ok.gov/health/Organization/HIPAA Privacy Rule/Oklahoma Standard Authorization Forms.html](http://www.ok.gov/health/Organization/HIPAA%20Privacy%20Rule/Oklahoma%20Standard%20Authorization%20Forms.html), or, in the alternative, a form that complies with 45 CFR § 164.508 and 43A O.S. § 1-109.

365:10-29-6. External review requests

A covered person or authorized representative requesting an external review pursuant to 36 O.S. § 6475.6 shall do so by submission of the External Review Request Form as set out in Appendix QQ.

365:10-29-7. Notice of initial determination

A notice of initial determination issued pursuant to Section 6475.8(C), 6475.9(B), 6475.10(A), or 6475.10(C) of Title 36 shall, in addition to providing notice of a right to appeal external review ineligibility to the Commissioner, provide that appeals shall be made in writing to the Oklahoma Insurance Department, Five Corporate Plaza, 3625 NW 56th Street, Suite 100, Oklahoma City, OK, 73112-4511.

365:10-29-8. Independent review organization application

(a) An independent review organization seeking approval to conduct external reviews pursuant to 36 O.S. § 6475.12(D) shall submit the application in Appendix RR as instructed, including all materials required by the application. Approval by this application will be effective until December 31, 2012.

(b) Notwithstanding Subsection (a) of this section, an independent review organization certified by the Oklahoma State Department of Health to do external review as of August 25, 2011, may apply one time for temporary approval as an independent review organization. This temporary approval will be in effect for 180 days, is non-renewable and must be replaced by approval pursuant to Subsection (a) of this section for continued approval to conduct external reviews. Applications for temporary approval must be received by the Insurance Department prior to December 31, 2011. To apply for temporary approval, an eligible independent review organization must provide:

- (1) Contact information for initiating external reviews, including:
 - (A) Name and title of contact person, or department;
 - (B) Phone number of contact person or department;
 - (C) Email of contact person or department;
 - (D) Mailing address, city, state, and zip;
 - (E) Website;
 - (F) Toll-free telephone number operating 24 hours a day;
 - (G) Fax number; and
 - (H) Any other necessary contact information used by the applicant;
- (2) A copy of the applicant's most recent certificate from URAC for Independent Review Organizations;
- (3) A list of specific areas of clinical expertise in which the applicant conducts independent reviews, if applicable;
- (4) A schedule of the applicant's fees;
- (5) A copy of the applicant's current Certificate of Authority provided by the Oklahoma Secretary of State;
- (6) An attestation and certification acknowledging understanding and compliance with the requirements of the Act.

365:10-29-9. Independent review organization recordkeeping and reporting requirements

Each independent review organization approved to conduct external reviews pursuant to 36 O.S. § 6475.12(D) shall maintain written records for the information required by 36 O.S. § 6475.15(A)(3) and Appendix SS, and shall submit Appendix SS within 31 calendar days of the end of each calendar year.

365:10-29-10. Health carrier recordkeeping and reporting requirements

Each health carrier subject to the Act shall maintain written records for the information required by 36 O.S. § 6475.15(B)(3) and Appendix TT, and shall submit Appendix TT within 31 calendar days of the end of each calendar year.

APPENDIX PP. NOTICE OF APPEAL RIGHTS [NEW]

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered.

Contact¹ us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.¹

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [INSERT ADDRESS OF WHERE APPEALS SHOULD BE SENT TO THE HEALTH CARRIER] within **180 days** of the date you receive our denial.² We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information

that we have that pertains to your claims. We will notify you of our decision in writing. Once our internal appeal process is exhausted (or waived by us), you may be entitled to file a request for external review.³

External Review³: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you request by submitting a request for external review within **4 months** after receipt of this notice to the Oklahoma Insurance Department, which can be contacted by mail at 3625 NW 56th Street, Oklahoma City, OK, 73112-4511, or by phone at 800-522-0071 or 405-521-2828. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us or contact your state insurance department.¹

¹ See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.

² Unless your plan or any applicable state law allows you additional time.

³ See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).

APPENDIX QQ. EXTERNAL REVIEW REQUEST FORM [NEW]

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Oklahoma Insurance Department within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME _____

Please Check One: Covered person/Patient Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Covered Person Phone #: Home (_____) _____ Work (_____) _____

INSURANCE INFORMATION

Insurer/HMO Name: _____

Covered Person Insurance ID#: _____

Insurance Claim/Reference #: _____

Insurer/HMO Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurer Telephone #: (_____) _____

EMPLOYER INFORMATION

Employer's Name: _____

Employer's Phone #: (_____) _____

Is the insurance you have through your employer a self-funded plan? _____. 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 voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Phone #: (_____) _____

Medical Record #: _____

REASON FOR HEALTH CARRIER DENIAL (Please check one)*

- The health care service or treatment is not medically necessary.
- The health care service or treatment is experimental or investigational.

*You can describe in your own words the health care service or treatment in dispute using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. Is this a request for an expedited appeal? Yes No

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Oklahoma Insurance Department. I understand that the independent review organization and the Oklahoma Insurance Department will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

Signature of Covered Person (or legal representative)*

Date

*(Parent, Guardian, Conservator or Other – Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

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

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

Signature of Covered Person (or legal representative)*
*(Parent, Guardian, Conservator or Other—Please Specify)

Date

Address of Authorized Representative: _____

City: _____ State: _____ Zip: _____

Phone #: Daytime (_____) _____ Evening (_____) _____

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. **YES**, I have included this completed application form signed and dated.
2. **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
3. **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
 - (a) Their decision is final and that I have exhausted all internal review procedures; or
 - (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Oklahoma Insurance Department for more information.

4. **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

*Call the Oklahoma Insurance Department at 800-522-0071 or 405-521-2828 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to:

Oklahoma Insurance Department
External Review
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK, 73112-4511

If you are requesting an expedited external review, call the Insurance Department at 800-522-0071 or 405-521-2828 before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

**CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL**

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Oklahoma Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: (_____) _____ Fax #: (_____) _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

Patient's Insurer Member ID#: _____

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 external review of the patient's appeal 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 carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Name (Please Print)

Signature

Date

**PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)**

I hereby certify that I am the treating physician for _____
(covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the Insured's treating physician, I hereby certify to the following:
(Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

1) <input type="checkbox"/>	The covered person has a terminal medical condition, or a life threatening condition, or a seriously debilitating condition.
2) <input type="checkbox"/>	The covered person has a condition that qualifies under one or more of the following: [please indicate which description(s) apply]:
i. <input type="checkbox"/>	Standard health care services or treatments have not been effective in improving the covered person's condition;
ii. <input type="checkbox"/>	Standard health care services or treatments are not medically appropriate for the covered person; or
iii. <input type="checkbox"/>	There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.
3) <input type="checkbox"/>	The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.
4) <input type="checkbox"/>	The health care service or treatment I have recommended would significantly less effective if not promptly initiated. Explain: _____ _____
5) <input type="checkbox"/>	It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments. Explain: _____ _____

**APPENDIX RR. APPLICATION FOR REGISTRATION AS AN INDEPENDENT
REVIEW ORGANIZATION [NEW]**

Oklahoma Insurance Department
 Five Corporate Plaza
 3526 NW 56th Street, Suite 100
 Oklahoma City, OK 73112
 405-521-2828

Application for Registration as an Independent Review Organization

Type of Entity: Corporation Partnership LLC Other _____

Contact Information for Application

Legal Name of Applicant	State of Domicile	Federal EIN	
Contact Person (Name and Title)	Phone ()	Email	
Business Address (Do not use PO Box)	City	State	Zip
Mailing Address (if different from business address)	City	State	Zip

Contact Information for Initiating External Reviews (also to be made available to carriers and consumers)

Contact Person (Name and Title) or Department	Phone ()	Email	
Mailing Address	City	State	Zip
Website	Toll-Free Telephone Number	Fax ()	
Other Contact Information			

A

Applicant Attestation and Certification

Applicant certifies that it will notify the Oklahoma Insurance Department immediately if its accreditation is lost with the American Accreditation Healthcare Commission/URAC. Applicant acknowledges that the Oklahoma Insurance Department may terminate this license if the applicant loses accreditation or no longer satisfies the minimum requirements for licensure.

Applicant acknowledges that payment of any fees associated with any external reviews conducted pursuant to 36 O.S. § 6475.1 et seq. are the sole responsibility of the health carrier whose medical decision is being reviewed. Applicant understands that it has no recourse against the Oklahoma Insurance Department or the state of Oklahoma to the extent that any health carrier fails to pay any medical reviewer fees. Applicant authorizes the Oklahoma Insurance Department to verify information with any federal, state, or local government agency, insurance company or accrediting organization.

Applicant acknowledges and represents that it understands and will comply with Oklahoma's insurance laws and the rules of the Oklahoma Insurance Department. Applicant hereby represents that it will comply with all requirements imposed under 36 O.S. § 6475.1 et seq. and assures that no conflict of interest or improper controlling interest as outlined in the statute exists. Applicant further agrees to maintain and provide to the Oklahoma Insurance Department the information set out in 36 O.S. § 6475.15.

I certify that, under penalty of perjury, I am the person named herein and know the contents thereof, and that all of the information submitted in this application and its attachments is true and complete. I attest that I have the authority and capacity to execute this certification on behalf of the applicant. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license denial or revocation and may subject me to civil or criminal penalties.

Signature of person who completed application

Signature of Officer, Director, or Board Member

Printed Name

Printed Name

Title

Title

Date

Date

Please provide the following as separate attachments:

1. A narrative description and an organizational chart to provide an overview of the applicant's operations.
2. A list of names and official capacities of all persons responsible for the applicant's external review program, including:
 - a. all members of the governing body, the officers and directors of a corporation, and the partners or associates of a partnership or association; and,
 - b. disclosure of any contracts or arrangements between those persons and the applicant, including any appearance of a conflict of interest as specified in 36 O.S. 6475.13.
3. A written statement addressing the determination of any conflicts of interest involving the applicant and all clinical reviewers.
4. A copy of your most recent certificate from American Accreditation HealthCare Commission/URAC for Independent Review Organizations.
5. A list of specific areas of clinical expertise in which you conduct independent reviews, if applicable.
6. A schedule of fees.
7. A copy of your current Certificate of Authority provided by the Oklahoma Secretary of State.
8. A narrative description of the quality assurance mechanism in place to meet the requirements of 36 O.S. 6475.13(A)(1).
9. A narrative description of the process utilized to maintain the confidentiality of personally identifiable health information and of clinical reviewers' and contract specialists' identities.
10. A copy of the policy and procedures that govern all aspects of the external review process for both standard and expedited reviews, including experimental and investigational treatments.

Please submit this application and all required attachments to:

Oklahoma Insurance Department
External Review Program
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112

**APPENDIX SS. INDEPENDENT REVIEW ORGANIZATION EXTERNAL REVIEW
ANNUAL REPORT FORM [NEW]**

Oklahoma Insurance Department

Independent Review Organization External Review Annual Report Form

External Review Annual Summary for 20_____		Due by January 31 for the previous calendar year.	
Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in Oklahoma only.			
1. IRO name:		Filing date:	
2. IRO license/certification no:			
3. IRO address:			
City, State, Zip:			
4. IRO Website:			
5. Name of person completing this form:			
Email:	Phone:	Fax:	
6. Person responsible for regulatory compliance and quality of external reviews:			
Name:	Title:		
7. Total number of requests for external review received from the Oklahoma Insurance Department during the reporting period:			
8. Number of standard external reviews:			
9. Average number of days IRO required to reach a final decision in standard reviews:			
10. Number of expedited reviews completed to a final decision:			
11. Average number of days IRO required to reach a final decision in expedited reviews:			
12. Number of medical necessity reviews decided in favor of the health carrier:			
Briefly list procedures denied:			

13. Number of medical necessity reviews decided in favor of the covered person:		
Briefly list procedures approved:		
14. Number of experimental/investigational reviews decided in favor of the health carrier:		
Briefly list procedures denied:		
15. Number of experimental/investigational reviews decided in favor of the covered person:		
Briefly list procedures approved:		
16. Number of reviews terminated as the result of a reconsideration by the health carrier:		
17. Number of reviews terminated by the covered person:		
18. Number of reviews declined due to possible conflict with	health carrier:	
	covered person:	
	health care provider:	
Describe possible conflicts of interest:		
19. Number of reviews declined due to other reasons not reflected in #18 above:		
Briefly list these reasons:		

Please submit to:
Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112-4511

**APPENDIX TT. HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT
FORM [NEW]**

Oklahoma Insurance Department

Health Carrier External Review Annual Report Form

External Review Annual Summary for 20_____		Due by January 31 for the previous calendar year.	
Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.			
1. Health carrier name:		Filing date:	
2. Health carrier address:			
City, State, Zip:			
3. Health carrier Website:			
4. Name of person completing this form:			
Email:	Phone:	Fax:	
5. Total number of external review requests received from the Oklahoma Insurance Department during the reporting period:			
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:			

Please submit to:
 Oklahoma Insurance Department
 Five Corporate Plaza
 3625 NW 56th Street, Suite 100
 Oklahoma City, OK 73112-4511