Pursuant to 28 TAC §19.1710, this form is promulgated by the Texas Department of Insurance.

COMPLETE THIS FORM BY TYPING OR PRINTING THE INFORMATION WITH BLACK INK

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Today's Date: Month_____ Day_____ Year_____

Name of Party Requesting IRO: _____ **Print Last Name, First Name and Middle Initial**	**Relationship to the Patient or Injured Employee: (Check one)** ☐ Self ☐ Person acting on behalf of patient or injured employee ☐ Provider acting on behalf of patient or injured employee ☐ Provider that received the denial

REASON FOR REQUEST FOR REVIEW BY AN IRO

Is the condition life-threatening? Check one: ☐ Yes ☐ No (This question does not apply if services have been received)	Is the review ordered by a Court? Check one: ☐ Yes ☐ No

DENIED SERVICES

Describe the health care services that are being denied (include dates):

_____

PATIENT/INJURED EMPLOYEE INFORMATION

Health Plan or Claim Identification Number:_____
(This number is usually found on the patient's ID card for health plans. The number identifies the patient to the insurance carrier. Enter the DWC claim number for workers' compensation cases.)

Date of Birth:*(month)* _____ *(day)* _____ *(year)*_____ Sex_____

Social Security Number _____-_____-_____

First Name_____Middle Name _____ Last Name _____Suffix_____

Street _____

City_____ State_____ Zip code_____

Phone: _____-_____ Fax: _____-_____

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PROVIDER THAT RECEIVED THE DENIAL

Name_____

Federal Tax Identification Number _____

Street_____

City_____ State_____ Zip code_____

Phone: _____-_____ Fax: _____-_____

PROVIDER ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF *(IF APPLICABLE)*

Name_____

Federal Tax Identification Number _____

Street_____

City_____ State_____ Zip _____

Phone number: _____-_____Fax number: _____-_____

PERSON ACTING ON PATIENT or INJURED EMPLOYEE'S BEHALF *(IF APPLICABLE)*

First Name_____Middle Name _____Last Name _____Suffix_____

Relation to patient _____

Street_____

City_____State_____Zip _____

Phone number: _____-_____Fax number: _____-_____

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You have the right to know about the information the Texas Department of Insurance (TDI) collects about you. You have a right to review or receive copies of information about yourself, including private information. TDI may withhold information for reasons other than to protect your right to privacy.

You have the right to request that TDI correct information that TDI has about you that is incorrect. Please contact the Agency Counsel Section of TDI's Legal & Compliance Division at (512) 475-1757 for more information. You may also visit the Corrections Procedures section of TDI's web page at www.tdi.state.tx.us

RELEASE (The release must be signed by the patient, or his or her legal guardian)
(NOT REQUIRED FOR WORKERS' COMPENSATION CASES)

I,_____ (**Print last name, first name and middle initial)**, the patient, parent, or patient's legal guardian ***(circle one)***, authorize the release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed_____ Date: *(MO)* _____ *(day)* _____*(yr.)* _____

Note: For chemical dependency or mental health treatment, please list the providers to which this release applies:

_____

_____

_____

___

_____

RETURN THIS FORM TO:

Name of Utilization Review Agent: _____

Address: _____

City: _____ State: _____ Zip: _____

Toll-Free Number: _____ Fax Number: _____

YOU CAN CALL THE TEXAS DEPARTMENT OF INSURANCE AT 1-888-TDI-2IRO (1-888-834-2476) FOR INFORMATION IF YOU HAVE ANY QUESTIONS ABOUT THE INDEPENDENT REVIEW PROCESS.