5300

April 23, 2010

[Name]
[Address]
[City, State, Zip]

Patient:
ID #:
Case #:
Provider:
Procedure/Service:
Date of Service:

Dear [Name of Appealing Party]:

The purpose of this correspondence is to advise you that PacifiCare Life and Health Insurance Company ("PacifiCare") has completed the review of your request for reconsideration of the services listed above.

Your appeal was reviewed by a PacifiCare [Insert reviewer: Medical Director, MD / Appeals Supervisor / Appeals Supervisor, RN / Appeals Specialist] who was not involved with the original decision. Upon review of the available information, it was determined that the previous decision should be upheld because the services are excluded under your plan.

The health plan coverage document states: [*Describe or refer to any applicable plan provisions on which the denial of the appeal was based*]

This concludes the mandatory appeal level. You may request an additional, voluntary external review as outlined on the next page.

You may obtain, free of charge, any documents, records and other information relevant to your appeal and/or a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based by submitting a written request to Appeals Department P.O. Box 400046 San Antonio TX 78229.

Individuals covered under the Employment Retirement Income Security Act (ERISA), may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act if all required reviews have been completed and the claim has not been approved.

If you feel that all or part of this claim has been wrongfully denied or rejected, you may have the matter reviewed by the California Department of Insurance at the address shown below.

State Insurance Regulatory Agency
California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013
Toll Free Number (800) 927-4357
Phone Number (213) 897-8921
TDD (800) 482-4833
Web Site www.insurance.ca.gov

If you have any questions regarding this matter, please contact me at (800) 624-7272, Monday through Friday, 8:00 am – 5:00 pm, Central Standard Time.

Sincerely,

[Name]
Appeals Specialist

Attachment: Application for Independent Medical Review
Enclosure: Pre-Addressed Envelope

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at:

PacifiCare SignatureElite℠ (PPO) 1-866-316-9776 TDHI: 1-866-816-2018
PacifiCare SignatureFreedom℠ (SDHP) 1-866-867-0700 TDHI: 1-866-867-0701

Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al:

1-800-730-7270 TDHI: 1-800-828-1120.

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357.

重要事項:您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。

如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼:

1-800-938-2300 聽語障專線 (TDHI): 1-800-828-1120.

請粵語或國語人士將為您提供協助。如需更多協助，請致電保險部熱線 1-800-927-4357。

INFORMATION AND INSTRUCTIONS REGARDING YOUR APPLICATION FOR INDEPENDENT MEDICAL REVIEW

Before you request an Independent Medical Review with the Department of Insurance, you are required to first file an appeal/grievance with the insurance company in an effort to resolve the issue(s). If you do not receive a satisfactory response after 30 days, then complete the application form, attach copies of any important papers that relate to your complaint and mail to the address shown on the application form. You may also attach additional sheets as necessary to explain and/or describe the situation and disagreement with your insurance company. We consider this information necessary to our review and within the powers and duties expressed in the California Insurance Code, Section 12921.3 and Section 10169. Please review our privacy statement regarding information we obtain from you.

Please be aware that a copy of your Application for Independent Medical Review will be provided to the insurance company and the Independent Medical Review Organization.

You have the right to provide information or documentation you believe will support your position in this review.

You may inspect the information you submit at any time as long as the department's case is maintained. All original documents will be returned to you upon completion of our handling.

APPLICATION FOR INDEPENDENT MEDICAL REVIEW MAY BE SUBMITTED TO THE DEPARTMENT OF INSURANCE FOR THE FOLLOWING TYPES OF PROBLEMS:

Denial of a claim due to the company's opinion that the treatment or service is not medically necessary or that it is experimental and excluded by a policy provision.

1 An offer of an amount less than that indicated in the policy due to the company's opinion of medical necessity.

2 Delay in settlement of a claim due to the disputed issue of medical necessity.

4. Denial of a claim for urgent or emergency services.

Under the Independent Medical Review process, one or more physicians will determine these issues and their decision will be binding on the insurance company.

STATE OF CALIFORNIA

Steve Poizner, Insurance Commissioner

DEPARTMENT OF INSURANCE
CLAIMS SERVICES BUREAU
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov
CSB-005 P
Revised: 12/21/06

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

Name _____ Work Phone: ( ) _____

Address _____ Home Phone: ( ) _____

City _____ Zip _____

Please be aware that a copy of this Application for Independent Medical Review will be provided to the insurance company. Also, please be advised that:

- **A decision not to participate in the independent review process may cause the forfeiture of any statutory right to pursue legal action against the insurer regarding the disputed health care service.**
- **Your consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any out-of-plan provider the insured may have consulted on the matter, is necessary to be signed by you.**
- **You have the right to provide information or documentation, either directly or through your provider, regarding any of the following:**
  - **The provider's recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.**
  - **Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.**
  - **Reasonable information supporting your position that the disputed health care service is or was medically necessary for the medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.**

1. Complete name of insurance company and policy/certificate number:

_____

2. Claim number and date(s) of medical service(s):

_____

3. Have you contacted the company to request an Independent Medical Review?

   Yes_____ No_____ (Provide copies of all correspondence)

4. If there is an imminent and serious threat to the health of the insured or claimant, please check and indicate the diagnosis.

_____

5. Briefly describe the disputed medical service or expense that you want referred to the Independent Medical Review Organization and list the physicians who have treated you for this condition. Use additional paper as needed.

_____

I hereby request Independent Medical Review of my dispute with the insurer. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the insurer, the California Department of Insurance and any Independent Medical Review Organization. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously release pursuant to this authorization. I attest that the information provided is accurate and truthful.

_____

Signature Date