State of California
Health and Human Services Agency
Department of Managed Health Care
INDEPENDENT MEDICAL REVIEW APPLICATION-English
DMHC 20-086 New: 01/02 Rev: 09/12

INDEPENDENT MEDICAL REVIEW APPLICATION

If you want to give another person the authority to assist you with your IMR, you must also complete the Authorized Assistant Form.

PATIENT INFORMATION

First Name_____ Middle Initial_____ Last Name_____

Name of Parent or Guardian if Filing for Minor Child_____

Street Address_____

City_____ State_____ Zip_____

Day Phone #_____ Evening Phone #_____

Health Plan Name_____

Patient's Membership Number_____

Patient's Date of Birth (mm/dd/yy)_____ Gender ☐ Male ☐ Female

Do you have Medi-Cal? ☐ Yes ☐ No

Do you have Medicare or Medicare Advantage? ☐ Yes ☐ No

Have you filed a complaint or grievance with your health plan? ☐ Yes ☐ No

Are you seeking payment for a service that you have already received? ☐ Yes ☐ No

YOUR HEALTH PROBLEM (Use a separate sheet and attach other documents if needed.)

1. What is your health condition or doctor's diagnosis?_____
2. What medical treatment or service are you requesting?_____
3. How would you like this case to be decided?_____
4. Do you have a condition that is a serious threat to your health? ☐ Yes ☐ No
   If "yes," please explain._____
5. Did your health plan say that the treatment you want is (check one):
   ☐ Not medically necessary ☐ Experimental or investigational ☐ Other (please explain)
6. List the name and phone number of your primary care doctor and other doctors who have seen, treated or advised you for your condition. Are they in your health plan's network? (Use a separate sheet if needed.)

   _____
7. I am asking for an Independent Medical Review (IMR) to make a decision about my problem with my health plan. If my issue does not qualify for an IMR, please review as a standard complaint. I allow my providers, past and present, and my health plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Department of Managed Health Care (DMHC) to review these records and information and send them to my health plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Patient or Parent Signature_____ **Date**_____

Mail or fax your form and any attachments to: **Help Center, Department of Managed Health Care, IMR Unit, 980 9th Street Suite 500, Sacramento CA 95814-2725; FAX: 916-255-5241**

IMR Application Instructions

If your health plan denies your request for medical services or treatment, you can file a complaint (grievance) with your plan. If you disagree with your plan's decision, you can ask the Help Center at the Department of Managed Health Care (DMHC) for an Independent Medical Review (IMR). An IMR is a review of your case by doctors who are not part of your health plan. If the IMR is decided in your favor, your plan must give you the service or treatment you requested. You pay no costs for an IMR.

You Can Apply for an IMR if Your Health Plan:

- Denies, changes, or delays a service or treatment because the plan determines it is not medically necessary.
- Will not cover an experimental or investigational treatment for a serious medical condition.
- Will not pay for emergency or urgent medical services that you have already received.

Before You Apply

In most cases, you must complete your health plan's complaint process before you apply for an IMR. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental / investigational, you do not have to take part in your plan's complaint process before you apply for an IMR.

You must apply for an IMR within six months after your health plan sends you a written response to your grievance. We may accept your application after six months, if we determine that circumstances prevented timely submission.

Please be aware that if you decide not to participate in the IMR process, you may be giving up your statutory rights to pursue legal action against your plan regarding the service or treatment you are requesting.

How to Apply

Fill out the IMR Application Form. Fill out the Authorized Assistant form if someone is helping you with your IMR. If you have medical records from *non-contracting providers* regarding your health care issue, please include them with your application. Your health plan will be required to obtain medical records from contracting providers.

Attach copies of letters or other documents about the treatment or service that your health plan denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return documents.

If you have questions about filling out your application form, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. There is no charge for this call.

Mail or fax your form and any attachments to:

Help Center
Department of Managed Health Care
980 9th Street Suite 500
Sacramento CA 95814-2725

FAX: 916-255-5241

What Happens if You Qualify for an IMR?

The Help Center will review your application and send you a letter within 7 days telling you if you qualify for an IMR. When all your information, including relevant medical records, is received, the IMR will be sent to the Review Organization who will make a decision within 30 days or within 3 to 7 days if your case is urgent. You will be notified of the decision made by the doctors who have reviewed your case. If the IMR is decided in your favor, your plan must give you the service or treatment you requested.

What Happens if You Do Not Qualify for an IMR?

Your issue will be reviewed through the Department's standard complaint process. You will receive a written notice of our decision within 30 days.

This Notice is Required by Law

- California's Knox-Keene Act gives the Department of Managed Health Care (DMHC) the authority to regulate health plans and investigate the complaints of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your health plan and to provide an Independent Medical Review if you qualify for one.
- You give us this information voluntarily. You do not have to give us this information.
- However, if you do not give us the information, we may not be able to investigate your complaint or provide an Independent Medical Review.
- We may share your personal information, as needed, with the health plan and the doctors who are doing the Independent Medical Review.
- We may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, 916-322-6727.
- The law that requires this notice is the Information Practices Act of 1977 (California Civil Code Section 1798.17)

State of California
Health and Human Services Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM-English
DMHC 20-160 New: 04/06 Rev: 09/12

AUTHORIZED ASSISTANT FORM

- If you want to give another person the authority to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (DMHC). I allow the DMHC and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Signature _____ Date _____

PART B: PERSON ASSISTING PATIENT

Name of Person Assisting (print) _____

Signature of Person Assisting _____

Address _____

City _____ State _____ Zip _____

Relationship to Patient _____

Daytime Phone # _____

Evening Phone # _____

☐ My power of attorney for health care decisions or other legal document is attached.