TEXAS DEPARTMENT OF INSURANCE
Financial Regulation Division - Managed Care Quality Assurance (103-6A)
333 Guadalupe, Austin, Texas 78701 ✯ PO Box 149104, Austin, Texas 78714-9104
(512) 676-6400 | F: (512) 490-1013 | (866) 554-4926 | TDI.texas.gov | @TexasTDI

DO NOT RETURN THIS FORM TO TDI

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)

INSTRUCTIONS

Instructions to Patient, Person Acting on Behalf or Representative of Patient/Employee, and Provider:
This form is being provided to you because your request for health care services has been denied as not medically necessary. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier. This is called an independent review by an Independent Review Organization or "IRO." You, your health care provider, or someone acting on your behalf or representative may file this form.

To request an independent review of your case, you must take the following action:

- Complete the Request for a Review by an Independent Review Organization form (TDI Form LHL009).
- Sign the form so the IRO can receive your medical records. (A signature is not required for Workers' Compensation cases).
- Return the completed form to the company that sent you the denial letter as soon as possible. The company's address and/or fax number are either listed on page four of this form or on the denial letters. DO NOT SEND THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE (TDI). (For Workers' Compensation cases, you must return this form – requesting an IRO – within 45 calendar days).

The company will forward your request for an independent review to TDI. Once TDI receives the request from the company, TDI will assign your case to an IRO. You will receive a letter from TDI identifying the IRO to whom your case has been assigned.

The timeframes for an IRO's decision are as follows:

Coverage Types	Health	Workers' Compensation Network (WCN)	Workers' Compensation Non-Network (WC)
Life Threatening	3 days	8 days	8 days
Denial of Prescription Drugs or Intravenous Infusions - Concurrent	3 days	NA	NA
Non-Life Threatening Preauthorization/Concurrent	20 days	20 days	20 days
Retrospective	20 days	30 days from receipt of IRO fee*	30 days from receipt of IRO fee**

*Carrier pays the fee.
**Requestor pays the fee. (However, if the requestor is an injured employee, carrier pays the fee.)

Instructions to URA/Carrier:

APPLIES TO HEALTH CASES ONLY: The entity that is submitting this request to TDI must indicate in the documentation that this is a denial of prescription drugs or intravenous infusions for which the enrollee is already receiving benefits.

There is no cost to you for the independent review. **Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective independent review will be required to pay the IRO fee prior to the IRO beginning its review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.**

For information about the independent review process, please call TDI at 1-866-554-4926, Option 7.

REQUEST FORM

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 ☐ Sub claimant (Workers' Compensation only)

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 this a denial of prescription drugs or intravenous infusions for which you are already receiving benefits? Check one: ☐ Yes ☐ No (This question does not apply to workers' compensation cases)
Is the review ordered by a Court? ☐ Yes ☐ No	

DENIED SERVICES

Describe the health care services that are being denied (include dates only if services have been performed):

_____

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: _____-_____

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'S/INJURED EMPLOYEE'S BEHALF *(IF APPLICABLE)*

First Name_____Middle Name _____Last Name _____Suffix_____

Relation to patient _____

Street_____

City_____State_____Zip _____

Phone number: _____-_____Fax number: _____-_____

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, list the providers to which this release applies:

_____
_____
_____
_____
_____

RETURN THIS FORM TO CARRIER/PAYOR OR UTILIZATION REVIEW AGENT

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Toll-Free Number: _____ Fax Number: _____

Notice About Certain Information, Laws and Practices
With few exceptions, you are entitled to be informed about the information the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy.

Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please visit the Corrections Procedure section of TDI's website.

FOR INFORMATION ABOUT THE INDEPENDENT REVIEW PROCESS, PLEASE CALL TDI AT 1-866-554-4926, OPTION 7.