

## Notice of Rescission of Preauthorization Exemption and Right to Request an Independent Review

### Important information and instructions

Date of notice \_\_\_\_\_

The preauthorization exemption for \_\_\_\_\_ will be rescinded effective \_\_\_\_\_.  
Health care service Date

- This form is being provided to you because we have determined that you no longer qualify for a preauthorization exemption.
- This notice includes a listing of claims that were retrospectively reviewed, the determination of medical necessity, and an identification of which claims were included the issuer's random sample for the purposes of evaluating continued eligibility for preauthorization exemption.
- You can now request that your preauthorization exemption be reviewed by a health care provider who is totally independent of the health maintenance organization or insurer that is subject to Insurance Code Chapter 4201, Subchapter N (issuer). This is called an independent review by an Independent Review Organization, or "IRO."
- To request an independent review of your preauthorization exemption, you must return this completed form to the issuer at the address listed below before the rescission effective date listed on this notice. Make a copy of this form for your records and remember do not return this form to the Texas Department of Insurance (TDI).

### Issuer information

Name of issuer \_\_\_\_\_

Address of issuer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_

Email \_\_\_\_\_

The issuer will forward your request for an independent review to TDI. Once TDI receives the request from the issuer, 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 IRO must make a determination within 30 days.



## Request for a Review by an IRO

Name of physician or provider \_\_\_\_\_

Federal tax identification number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_

Email \_\_\_\_\_

**Please indicate if you would like an IRO to review the issuer's random sample of claims, or a separate random sample of claims, if applicable:**

- Review issuer's random sample
- Review a separate random sample of claims, if available

## Signature

Physician or Provider \_\_\_\_\_ Date \_\_\_\_\_

Date Received by Issuer \_\_\_\_\_

## Questions

For information about the independent review process, please call TDI at 866-554-4926, Option 2 or email [MCQA@TDI.Texas.gov](mailto:MCQA@TDI.Texas.gov).