CATERPILLAR EXTERNAL REVIEW REQUEST FORM

This **EXTERNAL REVIEW REQUEST FORM** must be filed with **Caterpillar Inc. Prescription Drug Claims Benefit Review** within FOUR (4) MONTHS after receipt of a notice from Caterpillar for denial of payment on a claim or request for coverage of prescription drug coverage.

CLAIMANT NAME: _____

□ Patient □ Provider □ Authorized Representative

PATIENT INFORMATION

Patient Name: _____

Address: _____

_____

Patient Phone #: Home (____)_____Work (____)_____

PLAN INFORMATION

Plan Name: _____

Member ID#: _____

EMPLOYER INFORMATION

Employer's Name: _____

Employer's Phone#: (_____)_____

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address: _____

_____

Contact Person:_____

Phone:(____)_____ Fax:(_____)_____

REASON FOR HEALTH PLAN DENIAL (Please check one)

☐ Product Not On Formulary

☐ Required Step Therapy Not Met Prior to Using This Medication

☐ Prior Authorization Criteria Not Met For This Medication

☐ Other

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, and the reason(s) that it was denied and attach a copy of the Second Level Appeal denial letter you received.

_____

_____

*You may also describe in your own words the medication in dispute and why you are appealing this denial using the attached pages below.

EXPEDITED REVIEW

You may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? *Yes_____No _____

*If yes, please fill out the URGENT CARE CERTIFICATION on page 5.

SIGNATURE AND RELEASE OF MEDICAL RECORDS (This must be signed and dated by the patient.)

To appeal your health plan's denial, you must sign and date this external review request form and consent to the release of medical records.

I,_____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my health plan and my health care providers to release all relevant medical or treatment records to the independent review organization and Caterpillar Inc. I understand that the independent review organization and Caterpillar Inc. will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

_____ _____

Signature of Covered Person (or legal representative) * Date

*(Parent, Guardian, Conservator or Other – Please Specify)

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the disagreement you have with the requested medication's denial rationale from the 1st level appeal and the 2nd level appeal. Please clearly indicate the service(s) being denied and why you disagree.

Attach additional pages if necessary and include available pertinent medical records, any information you received from your Plan concerning the denials, any pertinent peer literature or clinical studies, and any additional information from your physician that you want the Independent Review Organization reviewer to consider:

WHAT TO SEND AND WHERE TO SEND IT: PLEASE CHECK BELOW

NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL THREE (3) ITEMS BELOW ARE INCLUDED

1. □ **YES**, I have included this completed application form signed and dated.

2. □ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that the health plan named in this application covers me.

3. □ **YES**, I have enclosed the letter from my health plan that states their decision is final and that I have exhausted all internal review procedures (Please submit the 2nd level appeal denial letter received.)

Fax or mail all paperwork to:

Fax (309) 285-8296

Caterpillar Inc.
Prescription Drug Claims Benefit Review
100 NE Adams St -AB4400
Peoria, Il 61629-4400

If you are requesting an external review, and need this form faxed or mailed to you, call the Caterpillar Inc. Prescription Drug Claims Review Line at 309-675-6415.

URGENT CARE CERTIFICATION 29 C.F.R §2560.503-1(m)(1)(i)

***Please Note: only fill out this page if the EXPEDITED REVIEW question on page 2 is marked 'Yes'.**

Pursuant to the claims and appeals procedures of the above-cited regulation, an expedited review process is available for claims involving urgent care. This certification is used to initiate expedited claims processing for prescription drug claims under the Plan.

I,_____, am a board-certified physician licensed to practice medicine in the State of_____with appropriate knowledge of the medical condition of_____(the "Claimant"). I have submitted a claim for coverage of_____by the Plan (the "Claim"). I hereby certify that application of the Plan's time period for making non-urgent care determinations:

(1) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or

(2) would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Accordingly, I hereby request that the Claim be processed under the Plan's expedited procedures for claims involving urgent care.

_____
Physician's Signature

_____
Physician's Printed Name

_____
Date