

**MYCARE OHIO - PROVIDER EXTERNAL MEDICAL REVIEW REQUEST FORM**

**Provider Instructions:** Submit your request within 30 calendar days of the MCE’s Provider Internal Appeal or Provider Claim Dispute Resolution decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. External Medical Review may also be requested if the MCE has not met the required Provider Internal Appeal or Provider Claim Dispute resolution time frame for a denial based on medical necessity. The following documentation must be submitted:

- Completed EMR request form**
- All appeal denial letters (including final appeal denial letter)**
- Medical Records**
- Optional: If there was a specific document that was previously submitted to the MCE, that you feel was not addressed, you may re-submit that document.

Submitting documentation:

- Upload to portal at <https://ecenter.hmsy.com/>
- New users can submit via secured email at [IMR@gainwelltechnologies.com](mailto:IMR@gainwelltechnologies.com). This will also initiate a request to establish portal access.

|   |  |
|---|--|
| Requesting Facility Name:   |  |
| Requesting Facility Address 1:                                    |  |
| Requesting Facility Address 2:                                    |  |
| Requesting Facility City, State, Zip Code:                        |  |
| Requesting Facility NPI:  |  |
| Requester's Name:   |  |
| Requester's Phone Number:   |  |
| Requester's Email:  |  |
| Billing Provider Name (if different from above):                  |  |
| Billing Provider NPI:   |  |
| Member/Patient Name:  |  |
| Member's/Patient's DOB:   |  |
| Healthplan (MCE) Member ID:                                       |  |
| Member's Medicare ID:   |  |
| Patient's Physician/Prescriber:                                   |  |
| Physician/Prescriber NPI:   |  |
| Healthplan (MCE) Name:  |  |
| Initial Appeal Date   |  |
| Date of Last Healthplan (MCE) Decision:                           |  |
| <b>Choose one of the following:</b>                               |  |
| For Service Authorization Denial report the Prior Authorization # |  |
| For a Claim Denial Report the ICN #                               |  |



**Request for Expedited Review**

A request for expedited review (within 3 business days) will only be approved if the following criteria is met. Otherwise, the standard timeframe (30 calendar days) will be applied to the external medical review. Permedion will notify the provider by phone and in writing within one business day of request if request for expedited review is denied and standard timeframe will be applied.

|   |  |
|---|--|
| Provider is requesting expedited review due to the following: |  |
|   | The standard resolution time frame could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function. |

|   |
|---|
| Rationale for Requesting Expedited Review |
|   |

I attest that the information provided in this application is true and accurate to the best of my knowledge.

|       |  |
|-------|--|
| Name: |  |
| Date: |  |

If you have any questions about Permedion’s external medical review process, please contact the Independent Medical Review department at 1-800-473-0802, Option 2.