

How do I get more information?

Contact the Department's Healthcare Review Program for more information by calling (919) 807-6860 or toll-free in North Carolina at (877) 885-0231.

You may also stop by the Department to make your inquiries at:

*N.C. Department of Insurance
Healthcare Review Program
Dobbs Building
430 N. Salisbury St., Room 4105
Raleigh, NC 27603*

How do I request an External Review?

To request an external review, you must complete a Request Form and meet the eligibility requirements for an external review. The Department can mail you a form, or you may access one on the Department Web site at www.ncdoi.com.

You may fax your form to (919) 807-6865 or send your completed request form to:

*North Carolina Department of Insurance
Healthcare Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201*

Healthcare Review Program staff will perform a preliminary review of your request to determine if you meet the eligibility requirements, and if you do, will arrange for the external review.

*North Carolina Department of Insurance
Healthcare Review Program
1201 Mail Service Center
Raleigh NC 27699-1201*

A Consumer's Guide To External Review

*North Carolina Department of Insurance
Healthcare Review Program*



*North Carolina Department of Insurance
Healthcare Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201*

*Phone: (919) 807-6860
NC Toll-free: 1-877-885-0231
Fax: (919) 807-6865*

What is External Review?

If you have had medical services denied by your insurance company and need assistance, we may be able to help you. The North Carolina Department of Insurance Healthcare Review Program offers a service known as “External Review.” This is an independent review of your denial and offers another option for resolving coverage disputes with your insurance company.

How can External Review help me?

Expert medical professionals who have no association with your insurance company perform the external review. They will review your case and if they determine that the denial was wrong, your insurance company will be required to pay for the services.

What sort of denial decisions are subject to External Review?

If your insurance company denies coverage on the basis that the services are not medically necessary, you may be eligible to request an external review. This type of denial is often called a “noncertification decision.” Sometimes denials for “cosmetic” or “experimental” services can be eligible for external review, depending on the nature of the services and how they relate to your medical circumstances.

What will the External Review cost me?

There is no cost for the person who requests the external review.

What type of insurance is not subject to External Review?

- Self-funded employer health plans
- Dental or vision
- Medicaid
- Long-term care insurance
- Medicare or Medicare supplements
- Specified disease insurance
- Workers compensation
- Credit or disability insurance
- Medical payments under homeowners or auto insurance

When can I request an External Review?

You can request a standard external review after you have exhausted your insurance company’s appeal process, are still not satisfied with the outcome and meet the eligibility requirements. Decisions on eligible cases made by the expert reviewers are required to be made within 45 days of your request.

What if I can’t wait 45 days for a decision?

If your insurance company has issued you a denial at any level and your medical condition requires an immediate decision to be made, you may request an expedited external review. There are certain qualifications that must be met in order for you to be eligible. If you are eligible for an expedited external review, a decision will be made by the medical expert reviewing your case within four days of your request. Please contact the Department for more information about requesting an expedited external review.

What makes me eligible for an External Review?

In order to be eligible for any external review:

- You must submit your request within 60 days of the date on the notice sent by your insurer that is the subject of your request. For a standard review, this is the final denial notice.
- Your request must relate to the type of insurance that is subject to external review. (see list of exclusions at left)
- Your request must be about an insurer’s denial on the grounds that a service is not medically necessary.
- You must have had coverage in effect at the time the services were provided or requested.
- The service must appear to be a covered benefit under the health insurance policy.
- For a standard review, you must have exhausted your healthplan’s internal appeals process and received a final determination that the services are denied.
- For an expedited external review, your medical condition must be such that the time required to receive a decision either with your insurer or, if appropriate, a standard review from the Department would seriously jeopardize your life or health.