Patient Name: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Insurance ID Number: [ID Number]

Case/Reference Number: [Authorization Reference Number]

Letter of Consent for External Independent Review

To: [Insurance Company Name / State Department of Insurance]

I, [Patient Name], am writing to formally request an external independent review of the denial of coverage for the following medical service/medication: [Name of Procedure or Drug].

By signing this letter, I provide my formal consent for the following:

- I authorize [Insurance Company Name] to release all relevant medical records, clinical notes, and documentation related to this denial to the appointed Independent Review Organization (IRO).
- I authorize [Healthcare Provider Name/Facility] to share any necessary protected health information (PHI) required to support this review.
- I designate [Name of Representative, if applicable] to act as my authorized representative throughout this appeal process.

I understand that the Independent Review Organization will conduct a clinical review of my case to determine if the requested service is medically necessary and should be covered under my health plan.

This consent is valid until the conclusion of the external review process or until I revoke it in writing.

Patient/Guardian Signature: _____

Date: [Date Signed]

Relationship to Patient: [Self / Parent / Legal Guardian]

Contact Information:
Address: [Street, City, State, Zip]

Phone Number: [Phone Number]
Email: [Email Address]