Consent to Release Medical Records
Request for External Review

To request an external review by a Board Certified Physician in the specialty concerning your appeal, you must sign and date this external review request form and consent to the release of medical records. A payment of $25 must accompany this form (check or money order). If the Reviewer agrees with you, the claim will be paid according to the Reviewer's decision and your $25 will be returned. If the Reviewer denies your claim, the $25 will not be returned.

I, (print name) _____, hereby request an external appeal. I authorize PEHP to release all medical or treatment records regarding this appeal to the Independent Reviewer. I understand that the Independent Reviewer will use this information to make a determination on my appeal. This release will be valid for one year and the information will not be released to anyone else or used for any other purposes.

_____ Date: _____

Signature of Member or parent, legal representative
or other (please identify) _____

PEHP Member ID Number: _____

Patient name: _____

Work/home/cell number:_____

Email address:_____

Claim number, PA number, or date(s) of service:_____

Send this form to:
PEHP Appeals and Policy Management Department
PO Box 3836
Salt Lake City, UT 84110-3836

* Be advised, this form only applies if the PEHP Executive Review Committee has denied your appeal and advised in your denial letter that this is your next appeal option. All other requests will be returned to sender. If you have questions, contact PEHP at 801-366-7555.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-765-7347 (TTY: 711)