



**BlueCross BlueShield of Illinois**

PO BOX 660603  
DALLAS, TX 75266-0603

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1911 2 AB 0.537 11

JAIME SCOTT SCHWARTZ, M.D.  
240 S LA CIENEGA BLVD STE 200  
BEVERLY HILLS CA 90211-3340



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January 08, 2024

TLC Surgical Center  
240 S La Cienega Blvd # 210  
Beverly Hills CA 90211-3324

**Subscriber:** Kemberli Anderson  
**Group/Sub. No.:** PK3519/000832780402  
**Claim No.:** U23233ABUB  
**Appeal ID No.:** 533000433  
**Appeal Type:** Provider  
  
**Phone:** (800)828-3116  
**Fax:** (918)551-2011  
**Email:** Appeals@bcbsil.com

**Subject: Your Appeal Results**

Dear TLC Surgical Center :

We received your appeal on December 12, 2023, for the denial of the below treatment or service(s). A Physician Reviewer who was not involved in the original denial reviewed your request and the related medical records. The Physician Reviewer's qualifications along with supporting documentation of this appeal decision are listed below.

<b>Appeal Decision</b>	After careful review of the information we have, the appeal request has been <b>denied</b> .	
<b>Physician Reviewer Information</b>	Physician Reviewer Qualifications	M.D.
	Physician Reviewer Specialty	General Surgery
	Physician Reviewer Credentials	Board Certified
	Physician Reviewer Sub Specialties	N/A
	Physician Reviewer Added Expertise	Bariatric Surgery and Surgical Oncology

<b>Service(s)</b>	Coverage for Suction assisted lipectomy; lower extremity		
<b>Member</b>	Kemberli Anderson	<b>Provider</b>	Jaime Scott Schwartz, M.D.
<b>Service Date(s)</b>	Pre Service	<b>Facility</b>	TLC Surgical Center
<b>Initial Decision</b>	Medical policy review determined that the service provided is not covered based on corporate medical policy criteria.	<b>Initial Decision Code</b>	745
<b>Initial Decision Date</b>	August 23, 2023	<b>Claim Amount</b>	\$0.00





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**Member Summary:**

Your doctor requested a service (lipectomy surgery) to treat your condition (lipedema). This condition caused an abnormal buildup of fat in your arms, legs, trunk, and abdomen. Your records show that your tissue is tender to touch. However, the tissue is thickened. Your doctor plans to perform multiple procedures. These procedures include liposuction of the arms, legs, trunk, and abdomen. Your records do not include chart documentation that you have tried standard treatments for at least three months without success (such as compression garments and manual lymph drainage). Records do not show that your tissue is soft to touch. Thus, the surgeries are not medically necessary for you. We cannot approve. Please call your doctor with any questions. We based this decision on the Blue Cross and Blue Shield of Illinois medical policy Surgery for Lipedema and Lymphedema SUR701.024 effective 2/1/2023, pages one and two.

**Procedure(s) Reviewed:**

15839 Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area  
15832 Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh  
15836 Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm  
15879 Suction assisted lipectomy; lower extremity  
15878 Suction assisted lipectomy; upper extremity  
15877 Suction assisted lipectomy; trunk  
15833 Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg

**This decision is based on:**

Blue Cross Blue Shield of Illinois (BCBSIL) Medical Policy SUR701.024 Surgery for Lipedema and Lymphedema

**Additional information can be found in the member's RYAN SPECIALTY, LLC Summary Plan Description and/or benefit booklet:**

Please refer to the "DEFINITIONS SECTION" which states:

"Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.





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MEDICALLY NECESSARY/MEDICAL NECESSITY.....means that a specific medical, health care, supply or Hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies. Please refer to the Exclusions – What Is Not Covered section of this booklet for additional information.

The Claim Administrator will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of this Plan, the Claim Administrator will take into account the information submitted to the Claim Administrator by your Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessary to the circumstances surrounding the hospitalization or other health care, it is determined that the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's condition.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so as described in the Claim Filing and Appeals Procedures section of this booklet.

Below are some examples, not an exhaustive list, of hospitalization or other health care services and supplies that are not Medically Necessary:

1. Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
2. Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
3. Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.



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4. Hospitalization or admission to a Skilled Nursing Facility or Residential Treatment Center, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.

5. The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.”

Please refer to the “EXCLUSIONS - WHAT IS NOT COVERED” section which states:

“Expenses for the following are not covered under your benefit program:

— Hospitalization, services and supplies which are not Medically Necessary.

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician’s office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient’s condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician’s office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician’s office.

— Continued Inpatient Hospital care, when the patient’s medical symptoms and condition no longer require their continued stay in a Hospital.

— Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient. — Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

— The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.



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The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY."

Verbal communication was attempted to Provider Jaime Scott Schwartz, MD on January 08, 2024 at approximately 10:10 AM CST.

Verbal communication was attempted to Member/Patient on January 08, 2024 at approximately 10:14 AM CST.

There was one internal appeal available which has now been exhausted. The plan may include an Independent External Review process at no cost to the member for medical necessity or experimental/investigational denials. See the attached (Important Information) to read about the Independent External Review process.

The member or the authorized representative acting on behalf of the member may request, free of charge, a copy of any benefit provision, guideline, protocol, or other similar criterion that we relied upon to make this determination. The member may also, upon request, obtain free copies of all documents relevant to the appeal including the specific treatment and diagnosis code(s) and any new or additional evidence (if applicable) not utilized during the prior reviews.

If we accept a form naming an authorized representative it is not an acceptance of assignment or waiver of any anti-assignment provisions of the member's benefits information. Please refer to the anti-assignment provisions, if any, in the Summary Plan Description and/or benefit booklet for more information.

To receive benefits, you must be eligible. The terms, rules and limits of your plan will be applied. Benefits will also be based on whether the Provider(s) used for treatment are eligible with the plan's network. For more details, please refer to your benefits information.





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If you have questions or to request copies, please contact Customer Service at (800)828-3116.

Sincerely,

*Julie S*

Julie S  
Appeals Specialist I  
Appeals Department

Cc: Kemberli Anderson  
Jaime Scott Schwartz, M.D.

Attachment:  
IL02.G.UGF.F  
Triage IL Federal IRO form





### IMPORTANT INFORMATION (Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

#### Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to: Blue Cross and Blue Shield of Illinois  
Claim Review Section  
PO Box 660603  
Dallas, TX 75266-0603

To file an appeal or if you have questions, please call 800-458-6024 (TTY/TDD: 711), send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members<sup>SM</sup> (BAM<sup>SM</sup>) at bcbsil.com

#### Authorized Representative

You can name a person to act for you (including an attorney) on your appeal or external review – known as an “authorized representative.” To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form.

#### Standard Appeal

You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:

- A copy of the decision letter or Explanation of Benefits (EOB)
- The reference number or claim number (often found on the decision letter or EOB)

You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your appeal.

#### What happens next?

We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

#### Expedited (Urgent) Appeal

You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call us at 800-458-6024 (TTY/TDD: 711) or fax your request to 918-551-2011. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling 800-458-6024.

#### What happens next?

If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request.



### Your Right to a Standard External (Outside) Review

You may ask for an external review with an Independent Review Organization (IRO) if your appeal was denied based on any of the reasons below. You may also ask for external review if we failed to give you a timely decision as stated in the Standard Appeal section above, and your claim was denied for one of these reasons:

- A decision about the medical need for or the experimental status of a recommended treatment
- A condition was considered pre-existing
- Your health care coverage was rescinded (see your Benefit Booklet for details), or
- Your claim was denied and involves services protected, or you believe to be protected, under the No Surprises Act

If your case qualifies for external review, an IRO will review your case (including any data you'd like to add), at no cost to you, and make a final decision. To ask for an external review, you'll need to complete the necessary form and submit it to BCBSIL. You may get a form by calling the number on your ID card. Unless your plan says otherwise, you have 4 months from the date you received the decision notice to file your external review request.

#### What happens next?

If you qualify for an External Review, an IRO will review your case and mail you its decision within 45 calendar days. That decision is final and binding on BCBSIL and you.

### Expedited (Urgent) External Review

You can ask for this type of review if:

- failure to get treatment in the time needed to complete an Expedited Appeal or an External Review would seriously harm your life, health or ability to regain maximum function;
- the request is about an admission, availability of care, continued stay or health care service that you received with emergency services, before your discharge from a facility;
- the request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started; or,
- we failed to give you a decision within 72 hours of your request for an expedited appeal

The IRO that does the expedited external review will decide if the covered person needs to complete the expedited (urgent) appeal process before the Expedited (Urgent) External Review can be started. If you think your case may qualify for an Expedited External Review, call 800-458-6024.

#### What happens next?

If you qualify for this type of review, the IRO will give you a decision within 72 hours.

### Notice about Provider Appeals

If you used an in-network provider, your provider may be able to file an appeal request for benefits you've been denied. You and your provider may file appeals separately and at the same time. Deadlines for filing appeals or external review requests are not delayed by appeals made by your provider UNLESS you have chosen your provider to act for you as your authorized representative. Choosing your provider to act for you must be done in writing. If your provider is acting on your behalf, then the provider must meet the deadlines you would have to meet to file such requests.

### Additional Rights

If you receive your benefits through an employer, you may also have the right to bring an action under Section 502(a) of a law called ERISA. To learn more, call the Employee Benefits Security Administration at 866-444-EBSA (3272).



### Department of Insurance

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, wish to file a complaint or wish to take up your matter with the IDOI, you may use either address below.

IDOI  
320 W. Washington St.  
Springfield, Illinois 62767-0001

Review Request: 877-850-4740  
Fax: 217-577-8495

IDOI, Office of Consumer Health Insurance  
122 S. Michigan Ave., 19<sup>th</sup> Floor  
Chicago, Illinois 60603

Complaints: 877-527-9431  
Email: DOI.InfoDesk@illinois.gov

IDOI Web: <https://mc.insurance.illinois.gov>

### Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>







If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય અથવા કોઈ બીજી વ્યક્તિને અસુ.બા.અમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसको सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bika anánilwo'ígíí, na'idíłkidgo, ts'idá bee ná ahóótí'i' t'áá níí'k'e níká a'doolwoł dóó bina'idíłkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'í' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.



## EXTERNAL REVIEW REQUEST

You may request external review, at no cost to you, for the following:

- An adverse determination or denial that involves medical judgment including a decision that the requested health care services are experimental or investigational;
- A determination on whether you are entitled to reasonable alternative standard for a reward under a wellness program;
- A determination on whether your Plan is complying with the non-quantitative treatment limitations that require parity in the application of medical management techniques; and
- Rescission of your coverage

Standard

☐

Expedited

☐

You can call 800-538-8833 to request an expedited external review at the same time you request an expedited internal review.

Today's Date: \_\_\_\_\_

### Subscriber's Information

### Patient's Information

Name:	Name:
ID:	ID:
Address:	Address:
Phone Number:	Phone Number:

Have you already received these health services? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when were the services received? (Month / Day / Year) \_\_\_\_\_

What was the Claim Number? \_\_\_\_\_

Please state the reason you believe the decision was not correct: \_\_\_\_\_

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## Urgent Care Claims

If your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision, you may ask for an expedited review by having your health care provider call us at 800-538-8833 or fax your request to 972-907-1868.

## Rescission of Coverage Claims

A rescission is the retroactive cancellation of your coverage.

Is this request for external review of a rescission? \_\_\_\_ Yes \_\_\_\_ No

We will notify you within 5 days of receiving your request, whether your request is eligible for external review or whether additional information is needed to make that determination.

If your request is eligible for external review, an Independent Review Organization will be randomly assigned. You will receive notice from the assigned IRO that will include information on where to send any additional documents. You will have 10 business days to submit additional documents to the IRO.

We will provide to the IRO, within 5 business days, all documents that were considered in our review.

The IRO will complete an expedited review within 72 hours after assignment and will complete a standard external review within 45 days after assignment. You will receive written notice of the decision from the IRO.

The decision is binding except to the extent there are other remedies available under applicable law. If the IRO overturns our decision, we will provide coverage and or payment for the claim subject to any member share for deductible, co-insurance and co-payments.

### Please sign and date the form:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

I am the: ☐ Covered Person ☐ Parent or Legal Guardian ☐ Authorized Representative ☐ Provider of Record

**Authorized representative:** You can represent yourself, or you may ask another person, to act as your authorized representative. You may revoke this authorization at any time.

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
to pursue my external review appeal on my behalf.

\_\_\_\_\_  
Date: \_\_\_\_\_

*Signature of Covered Person or Legal Representative*

**NOTE:** The covered person must sign this form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form.

**Please send any additional clinical information to support your request for external review along with this form to:**

BCBSIL – External Review Request  
PO Box 660603  
Dallas, TX 75266-0603

or

Fax: 972-907-1868





**BlueCross BlueShield of Illinois**

PO BOX 660603  
DALLAS, TX 75266-0603

\*\*\*\*\*ALL FOR AADC 900  
1910 2 AB 0.537 11

TLC SURGICAL CENTER  
240 S LA CIENEGA BLVD # 210  
BEVERLY HILLS CA 90211-3324



ILAPPEALS

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Env[1.910] 1 of 7



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January 08, 2024

TLC Surgical Center  
240 S La Cienega Blvd # 210  
Beverly Hills CA 90211-3324

**Subscriber:** Kemberli Anderson  
**Group/Sub. No.:** PK3519/000832780402  
**Claim No.:** U23233ABUB  
**Appeal ID No.:** 533000433  
**Appeal Type:** Provider

**Phone:** (800)828-3116  
**Fax:** (918)551-2011  
**Email:** Appeals@bcbsil.com

### Subject: Your Appeal Results

Dear TLC Surgical Center :

We received your appeal on December 12, 2023, for the denial of the below treatment or service(s). A Physician Reviewer who was not involved in the original denial reviewed your request and the related medical records. The Physician Reviewer's qualifications along with supporting documentation of this appeal decision are listed below.

<b>Appeal Decision</b>	After careful review of the information we have, the appeal request has been <b>denied</b> .	
<b>Physician Reviewer Information</b>	Physician Reviewer Qualifications	M.D.
	Physician Reviewer Specialty	General Surgery
	Physician Reviewer Credentials	Board Certified
	Physician Reviewer Sub Specialties	N/A
	Physician Reviewer Added Expertise	Bariatric Surgery and Surgical Oncology

<b>Service(s)</b>	Coverage for Suction assisted lipectomy; lower extremity		
<b>Member</b>	Kemberli Anderson	<b>Provider</b>	Jaime Scott Schwartz, M.D.
<b>Service Date(s)</b>	Pre Service	<b>Facility</b>	TLC Surgical Center
<b>Initial Decision</b>	Medical policy review determined that the service provided is not covered based on corporate medical policy criteria.	<b>Initial Decision Code</b>	745
<b>Initial Decision Date</b>	August 23, 2023	<b>Claim Amount</b>	\$0.00







January 08, 2024

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**Member Summary:**

Your doctor requested a service (lipectomy surgery) to treat your condition (lipedema). This condition caused an abnormal buildup of fat in your arms, legs, trunk, and abdomen. Your records show that your tissue is tender to touch. However, the tissue is thickened. Your doctor plans to perform multiple procedures. These procedures include liposuction of the arms, legs, trunk, and abdomen. Your records do not include chart documentation that you have tried standard treatments for at least three months without success (such as compression garments and manual lymph drainage). Records do not show that your tissue is soft to touch. Thus, the surgeries are not medically necessary for you. We cannot approve. Please call your doctor with any questions. We based this decision on the Blue Cross and Blue Shield of Illinois medical policy Surgery for Lipedema and Lymphedema SUR701.024 effective 2/1/2023, pages one and two.

**Procedure(s) Reviewed:**

15839 Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area  
15832 Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh  
15836 Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm  
15879 Suction assisted lipectomy; lower extremity  
15878 Suction assisted lipectomy; upper extremity  
15877 Suction assisted lipectomy; trunk  
15833 Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg

**This decision is based on:**

Blue Cross Blue Shield of Illinois (BCBSIL) Medical Policy SUR701.024 Surgery for Lipedema and Lymphedema

**Additional information can be found in the member's RYAN SPECIALTY, LLC Summary Plan Description and/or benefit booklet:**

Please refer to the "DEFINITIONS SECTION" which states:

"Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.



January 08, 2024

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<b>Email:</b>	Appeals@bcbsil.com

**MEDICALLY NECESSARY/MEDICAL NECESSITY**.....means that a specific medical, health care, supply or Hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies. Please refer to the Exclusions – What Is Not Covered section of this booklet for additional information.

The Claim Administrator will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of this Plan, the Claim Administrator will take into account the information submitted to the Claim Administrator by your Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessary to the circumstances surrounding the hospitalization or other health care, it is determined that the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's condition.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so as described in the Claim Filing and Appeals Procedures section of this booklet.

Below are some examples, not an exhaustive list, of hospitalization or other health care services and supplies that are not Medically Necessary:

1. Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
2. Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
3. Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.







January 08, 2024

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<b>Email:</b>	Appeals@bcbsil.com

4. Hospitalization or admission to a Skilled Nursing Facility or Residential Treatment Center, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.

5. The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members."

Please refer to the "EXCLUSIONS - WHAT IS NOT COVERED" section which states:

"Expenses for the following are not covered under your benefit program:

— Hospitalization, services and supplies which are not Medically Necessary.

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

— Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.

— Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient. — Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

— The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.





January 08, 2024

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**Email:** Appeals@bcbsil.com

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY."

Verbal communication was attempted to Provider Jaime Scott Schwartz, MD on January 08, 2024 at approximately 10:10 AM CST.

Verbal communication was attempted to Member/Patient on January 08, 2024 at approximately 10:14 AM CST.

There was one internal appeal available which has now been exhausted. The plan may include an Independent External Review process at no cost to the member for medical necessity or experimental/investigational denials. See the attached (Important Information) to read about the Independent External Review process.

The member or the authorized representative acting on behalf of the member may request, free of charge, a copy of any benefit provision, guideline, protocol, or other similar criterion that we relied upon to make this determination. The member may also, upon request, obtain free copies of all documents relevant to the appeal including the specific treatment and diagnosis code(s) and any new or additional evidence (if applicable) not utilized during the prior reviews.

If we accept a form naming an authorized representative it is not an acceptance of assignment or waiver of any anti-assignment provisions of the member's benefits information. Please refer to the anti-assignment provisions, if any, in the Summary Plan Description and/or benefit booklet for more information.

To receive benefits, you must be eligible. The terms, rules and limits of your plan will be applied. Benefits will also be based on whether the Provider(s) used for treatment are eligible with the plan's network. For more details, please refer to your benefits information.





**BlueCross BlueShield  
of Illinois**

January 08, 2024

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Beverly Hills CA 90211-3324

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<b>Fax:</b>	(918)551-2011
<b>Email:</b>	Appeals@bcbsil.com

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If you have questions or to request copies, please contact Customer Service at (800)828-3116.

Sincerely,

*Julie S*

Julie S  
Appeals Specialist I  
Appeals Department

Cc: Kemberli Anderson  
Jaime Scott Schwartz, M.D.

Attachment:  
IL02.G.UGF.F  
Triage IL Federal IRO form



### IMPORTANT INFORMATION (Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

#### Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to: Blue Cross and Blue Shield of Illinois  
Claim Review Section  
PO Box 660603  
Dallas, TX 75266-0603

To file an appeal or if you have questions, please call 800-458-6024 (TTY/TDD: 711), send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members<sup>SM</sup> (BAM<sup>SM</sup>) at bcbsil.com

#### Authorized Representative

You can name a person to act for you (including an attorney) on your appeal or external review – known as an “authorized representative.” To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form.

#### Standard Appeal

You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:

- A copy of the decision letter or Explanation of Benefits (EOB)
- The reference number or claim number (often found on the decision letter or EOB)

You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your appeal.

#### What happens next?

We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

#### Expedited (Urgent) Appeal

You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call us at 800-458-6024 (TTY/TDD: 711) or fax your request to 918-551-2011. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling 800-458-6024.

#### What happens next?

If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request.



### Your Right to a Standard External (Outside) Review

You may ask for an external review with an Independent Review Organization (IRO) if your appeal was denied based on any of the reasons below. You may also ask for external review if we failed to give you a timely decision as stated in the Standard Appeal section above, and your claim was denied for one of these reasons:

- A decision about the medical need for or the experimental status of a recommended treatment
- A condition was considered pre-existing
- Your health care coverage was rescinded (see your Benefit Booklet for details), or
- Your claim was denied and involves services protected, or you believe to be protected, under the No Surprises Act

If your case qualifies for external review, an IRO will review your case (including any data you'd like to add), at no cost to you, and make a final decision. To ask for an external review, you'll need to complete the necessary form and submit it to BCBSIL. You may get a form by calling the number on your ID card. Unless your plan says otherwise, you have 4 months from the date you received the decision notice to file your external review request.

**What happens next?**

If you qualify for an External Review, an IRO will review your case and mail you its decision within 45 calendar days. That decision is final and binding on BCBSIL and you.

### Expedited (Urgent) External Review

You can ask for this type of review if:

- failure to get treatment in the time needed to complete an Expedited Appeal or an External Review would seriously harm your life, health or ability to regain maximum function;
- the request is about an admission, availability of care, continued stay or health care service that you received with emergency services, before your discharge from a facility;
- the request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started; or,
- we failed to give you a decision within 72 hours of your request for an expedited appeal

The IRO that does the expedited external review will decide if the covered person needs to complete the expedited (urgent) appeal process before the Expedited (Urgent) External Review can be started. If you think your case may qualify for an Expedited External Review, call 800-458-6024.

**What happens next?**

If you qualify for this type of review, the IRO will give you a decision within 72 hours.

### Notice about Provider Appeals

If you used an in-network provider, your provider may be able to file an appeal request for benefits you've been denied. You and your provider may file appeals separately and at the same time. Deadlines for filing appeals or external review requests are not delayed by appeals made by your provider UNLESS you have chosen your provider to act for you as your authorized representative. Choosing your provider to act for you must be done in writing. If your provider is acting on your behalf, then the provider must meet the deadlines you would have to meet to file such requests.

### Additional Rights

If you receive your benefits through an employer, you may also have the right to bring an action under Section 502(a) of a law called ERISA. To learn more, call the Employee Benefits Security Administration at 866-444-EBSA (3272).





### Department of Insurance

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, wish to file a complaint or wish to take up your matter with the IDOI, you may use either address below.

IDOI  
320 W. Washington St.  
Springfield, Illinois 62767-0001  
Review Request: 877-850-4740  
Fax: 217-577-8495

IDOI, Office of Consumer Health Insurance  
122 S. Michigan Ave., 19<sup>th</sup> Floor  
Chicago, Illinois 60603  
Complaints: 877-527-9431  
Email: DOI.InfoDesk@illinois.gov

IDOI Web: <https://mc.insurance.illinois.gov>

### Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>





If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બાજુ વ્યક્તિને અસુ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	याँदे आपके, या आप जिसको सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ía'da bíká anánílwo'ígíí, na'ídiłkídogo, ts'ídá bee ná ahóótí'i' t'áá níik'e níká a'doolwoł dóo bína'ídiłkídígíí bee níh h odoonih. Ata'dahalne'ígíí bich'í' hodíílnih kwe'e 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.



## EXTERNAL REVIEW REQUEST

You may request external review, at no cost to you, for the following:

- a. An adverse determination or denial that involves medical judgment including a decision that the requested health care services are experimental or investigational;
- b. A determination on whether you are entitled to reasonable alternative standard for a reward under a wellness program;
- c. A determination on whether your Plan is complying with the non-quantitative treatment limitations that require parity in the application of medical management techniques; and
- d. Rescission of your coverage

**Standard**

☐

**Expedited**

☐

You can call 800-538-8833 to request an expedited external review at the same time you request an expedited internal review.

Today's Date: \_\_\_\_\_

### Subscriber's Information

### Patient's Information

<b>Name:</b>	<b>Name:</b>
<b>ID:</b>	<b>ID:</b>
<b>Address:</b>	<b>Address:</b>
<b>Phone Number:</b>	<b>Phone Number:</b>

Have you already received these health services? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when were the services received? (Month / Day / Year) \_\_\_\_\_

What was the Claim Number? \_\_\_\_\_

Please state the reason you believe the decision was not correct: \_\_\_\_\_

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## Urgent Care Claims

If your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision, you may ask for an expedited review by having your health care provider call us at 800-538-8833 or fax your request to 972-907-1868.

## Rescission of Coverage Claims

A rescission is the retroactive cancellation of your coverage.

Is this request for external review of a rescission? \_\_\_\_ Yes \_\_\_\_ No

We will notify you within 5 days of receiving your request, whether your request is eligible for external review or whether additional information is needed to make that determination.

If your request is eligible for external review, an Independent Review Organization will be randomly assigned. You will receive notice from the assigned IRO that will include information on where to send any additional documents. You will have 10 business days to submit additional documents to the IRO.

We will provide to the IRO, within 5 business days, all documents that were considered in our review.

The IRO will complete an expedited review within 72 hours after assignment and will complete a standard external review within 45 days after assignment. You will receive written notice of the decision from the IRO.

The decision is binding except to the extent there are other remedies available under applicable law. If the IRO overturns our decision, we will provide coverage and or payment for the claim subject to any member share for deductible, co-insurance and co-payments.

### Please sign and date the form:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

I am the: ☐ Covered Person ☐ Parent or Legal Guardian ☐ Authorized Representative ☐ Provider of Record

**Authorized representative:** You can represent yourself, or you may ask another person, to act as your authorized representative. You may revoke this authorization at any time.

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
to pursue my external review appeal on my behalf.

\_\_\_\_\_  
*Signature of Covered Person or Legal Representative* Date: \_\_\_\_\_

**NOTE:** The covered person must sign this form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form.

**Please send any additional clinical information to support your request for external review along with this form to:**

BCBSIL – External Review Request  
PO Box 660603  
Dallas, TX 75266-0603

or

Fax: 972-907-1868