ALFRED W. GROSS
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
http://www.scc.virginia.gov/division/boi

April 1, 2008

Administrative Letter 2008-05

To: All Insurers Licensed to Write Accident and Sickness Insurance, All Licensed Health Maintenance Organizations, and All Licensed Health Services Plans

Re: Rules Governing Independent External Review of Final Adverse Utilization Review Decisions (14 VAC 5-215-10 et seq.)

This letter serves to notify carriers of a change to the *Authorization to Release Medical Information* form used in connection with external appeals of final adverse decisions made by utilization review entities. Effective immediately, the form no longer calls for the covered person's social security number. A copy of the revised form is attached to this Administrative letter for your convenience. In addition, this Administrative Letter and the form may be found on the Bureau's website at www.scc.virginia.gov/division/boi.

All carriers are asked to replace existing stocks of these forms with this revised form as soon as reasonably possible.

Questions relating to this Administrative Letter should be directed to:

Kim R. Naoroz
Manager
External Appeals
Bureau of Insurance Life and Health Division
P.O. Box 1157
Richmond, VA 23218
Phone: 804-371-9915
Kim.Naoroz@scc.virginia.gov

Cordially,

Alfred W. Gross
Commissioner of Insurance

AWG/krn
Attachment – Form 215D (rev. 4/08)

Form 215D
(rev. 4/08)

State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
(804) 371-9913

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization must be signed by (i) the covered person; (ii) the covered person's parent, legal guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

Any health care provider of services or supplies, insurance company, or any other organization, institution or person that has a record or knowledge regarding the covered person named below and such person's health, is hereby authorized to furnish to the Bureau of Insurance, or its designated impartial health entity, information concerning services or supplies provided or proposed to be provided to such covered person.

If I am not the covered person listed below, I hereby certify that I am authorized by law to execute this authorization on the covered person's behalf.

This authorization is given for the purpose of conducting an external review of a final adverse decision made by a utilization review entity. This authorization is valid for 90 days from the date below.

Printed Name of Covered Person: _____

Covered Person's Date of Birth: _____

Signature of Covered Person: _____

Date: _____

OR

Other Authorized Signature: _____

Date: _____