NEW YORK STATE | Department of Health | Medical Indemnity Fund

Request Review of Prior Authorization Denial

Requests for a review must be made within 30 days of your receipt of the denial

NYMIF Enrollee Name: _____ **Today's Date** ____ / ____ / ____

NYMIF Enrollee ID: **NYS** _____

Name of Person(s) Submitting Request: _____

Signature of Person(s) Submitting Request: _____

Relationship to Enrollee: _____

Address of Person Requesting the Review:

Street Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Phone: _____

Authorization Denial Date: _____ / _____ / _____

Please specify the items denied for which you are seeking review:

_____

_____

_____

_____

Please state the reason(s) you believe the determination was incorrect:

_____

_____

_____

_____

In addition to this form, what documents (if any) are you including with this Request for Review?

_____

_____

_____

_____

The review will be conducted by a hearing officer. Please indicate that type of review you are requesting:
(Please check only ONE)

☐ A review based on documents submitted by both parties (you and the Fund Administrator)

☐ A review in the form of a hearing conducted by telephone

☐ A review in the form of a hearing conducted in person

If you would like a hearing in person, do you need any reasonable accommodations?

No: ☐ **Yes**: ☐ **Please explain**: _____

If you want a hearing, is an interpreter needed and if so, for what language?

No: ☐ **Yes**: ☐ **Language**: _____

_____ _____/_____/_____

Signature **Date**

In addition to a formal review by a hearing officer, you may request an informal conference with the Fund Administrator, Public Consulting Group. If requested, an informal conference will be scheduled prior to the formal review.

Please complete this form and return it to Public Consulting Group. Your request for a formal review must be made within 30 days of when you receive the denial letter.

Please send this form to:

Medical Indemnity Fund c/o PCG
P.O. Box 7315 Albany, N.Y. 12224