PCOT
Physicians Contracting Organization of Texas

Committed to patient advocacy.
Quality healthcare. Independent physicians.

Recipient of the
Best Practice Management Award
for 2001 by the IPA Association of
America

August 12, 2002

TO ALL PCOT Membership

Gentlemen and Ladies:

Humana/Choicecare has requested that PCOT messenger out to the membership, the terms of their contract. As a messenger model IPA, each physician has the right to accept or reject all contract offers. The Humana/Choicecare contract does not meet the contracting criteria of PCOT as follows:

1. Would not agree to TSBME guidelines for copying of medical records. (standard is a reasonable fee not more than $25.00 for the first 20 pages and .15 for each page thereafter, plus actual costs of mailing, shipping, or delivery.) Humana/Choicecare will reimburse .25 per page but not to exceed $25.00 per record.
2. Would not amend contract language to delete "class-bases arbitration shall not be permitted." This would limit a physician from bringing a class action suit against Humana/Choicecare regardless of Humana's action.
3. Would not amend contract language that neither party may assign or transfer any of its rights or obligations without prior consent of the other party. The contract allows unilateral right of assignment and amendment by Humana/Choicecare with a 30-day notification. No response to amendment constitutes acceptance of the amendment. This would allow Humana/Choicecare to amend the contract without physician consent and the only action to not accepting the change would be termination of the contract. Also if the physician did not respond timely, within 30 days, the amendment would be enforced with or without the consent of the physician.
4. Will not amend language that would not allow for retroactive denial of payment if the provider properly verifies eligibility and benefits prior to services rendered. PCOT does not always obtain this language, although it is always requested. This will allow Humana/Choicecare, after verification of benefits and eligibility, to recoup monies paid to the physician, if the member/insured was not eligible although verified by the physician clinic. PCOT ask for language to be added regarding notices for refunds should not be recouped from future monies without a 30-day time frame to investigate. Humana/Choicecare would not add language, but states they will work with any physician and allow reasonable time to investigate prior to recouping monies from future claim payments.
5. Would not amend the term of the contract to one year in lieu of a multi-year two-year commitment.

935 S. Baxter, Suite 101 Tyler, Texas 75701
903-526-3268 or 1-888-248-1907 Fax: 903-526-2320
info@pcot.org www.PCOT.org

6. Would not agreed to the language request that neither party may assign or transfer any of its rights or obligations under this agreement without prior consent of the other party. This would allow another health plan to acquire Humana/Choicecare prior to any notification to participating providers. Most acquisitions continue under the contract terms until re-negotiated with the participating physician.
7. Each physician needs to review the reimbursement schedule to determine if it is acceptable. The Medicare schedule will be updated annually by April 1st.
8. Humana/Choicecare requires each physician to sign a separate letter of understanding as part of the opt-in process stating that if the IPA contract is terminated, the physician will continue to be participating. This protects the network in case the IPA ceases to contract for any reason.

Please indicate your practice's plan to participate in the Humana/Choicecare contract by checking one of the boxes below. This response should be mailed to PCOT, ~~935 S. Baxter, Ste. 101~~, Tyler, TX, 75701 or faxed to the attention of Belinda Cook at 526-2320. 1310 Doctor's Dr, Ste B

Sincerely,

Brenda Shepherd

Brenda Shepherd, MBA
Executive Director

—— Yes, our practice will accept these fees and all physicians in the practice will participate in the Humana/Choicecare contract.

—— No, our practice does not wish to participate in the Humana/Choicecare contract.

Date:_____ Practice
Name:_____

Authorized Signature:_____

Tax I.D. No:_____
Print Physician Name(s)

ATTACHMENT F

LETTER OF AGREEMENT

Health Value Management, Inc. d/b/a ChoiceCare Network (hereinafter referred to as "**ChoiceCare**") and _____ (hereinafter referred to as "**IPA**") entered into an Independent Practitioner Association Participation Agreement (hereinafter "**Agreement**") effective as of _____, 20_____.

WHEREAS, the undersigned practitioner is a member of **IPA**, and a participating practitioner pursuant to the Agreement (hereinafter referred to as "**IPA Practitioner**").

WHEREAS, IPA Practitioner and **ChoiceCare** are entering into this Letter of Agreement in order to provide for the orderly transition and continuity of care for Members in the event of the termination of the Agreement or in the event **IPA** ceases operations.

NOW, THEREFORE, in the event the Agreement is terminated for any reason or **IPA** discontinues operations for any reason, **ChoiceCare** and IPA Practitioner agree as follows:

IPA Practitioner shall abide by all of the terms and conditions set forth in the Agreement, and by all **ChoiceCare** and Payor policies and procedures established and revised from time to time by **ChoiceCare** or Payor, as applicable, including but not limited to quality assurance, quality improvement, risk management, utilization management, credentialing, recredentialing and grievances/appeals.

IPA Practitioner unconditionally authorizes **ChoiceCare** and **IPA** to share information, including but not limited to credentialing, recredentialing, quality management, and utilization management information as related to the treatment of Members. However, it is expressly understood that the information shall not be shared with anyone not a party to the Agreement, unless required by law or pursuant to prior written consent of IPA Practitioner.

IPA Practitioner acknowledges that IPA Practitioner has been provided an opportunity to read the Agreement and is familiar with its terms, including, without limitation, reimbursement provisions, all of which are incorporated herein by reference. Unless otherwise provided, defined terms herein shall have the meaning given such terms in the Agreement.

IPA Practitioner shall look solely to Payor for payment for Covered Services prior to the effective date or termination of the Agreement or the date **IPA** ceases operations and agrees that payments made by Payors to **IPA** prior to such date for Covered Services rendered to Members by IPA Practitioner constitutes payment in full to IPA Practitioner.

IPA Practitioner shall continue to provide health care services under the terms and conditions of the Agreement for a period of ninety (90) days following the effective date of the termination or the **IPA** discontinues operations. **ChoiceCare** may terminate such IPA Practitioner's participation in the **ChoiceCare** network at any time after such date upon written notice to IPA Practitioner.

IN WITNESS WHEREOF, the parties have executed this Agreement intending to be bound hereby.

CHOICECARE	IPA PRACTITIONER
By: _____	Signature: _____
Title: _____	Print Name: _____
Date: _____	Date: _____

Humana/ChoiceCare Quick Reference Sheet

Category	Response
Fee Schedule	150% of Medicare for E&M; 180% of Medicare for all other codes; Anesthesia at $52.00 per unit.
Covered Lives	State of Texas = 155,000
Major Clients	Humana; Employers Health; Pioneer Drilling/Mustang and Linbarger
Hospitals in Network	ETMC System; UT Health;Carenow System; Baylor System; Tyler Cty Hospital; Children's Medical Ctr - Dallas; Presby System;Palestine Regional; Medical Center at Terrell; Seton; Central Texas Health System; Brackenridge;St. Davids- Austin
Language Additions	1. Delegation of credentialing
	2. Malpractice limits to community norm of 200/600
	3. Copying of medical records up to .25 cents per page and not to exceed $25.00 per record.
	4. Waiver of member cost share amounts under financial hardship circumstances.
	5. Physician has a reasonable amount of time to research refund request prior to Choicecare intent to deduct from future monies. Time frame defined as 30 days.
	6. De-selection of physician is not allowed unless for credentialing issue; imminent harm to patient; or utilization problems.
	7. Physician has right of appeal if de-selected per SB 383
	8. Must adhere to all state and federal laws (prompt pay)
	9. Contract does not allow retroactive denial of payment if the physician properly verifies eligibility and benefits prior to services rendered
	10. Emergency Care defined as under the prudent layperson standard.
	11. ID cards must have Choicecare network logo or no discount can be taken - This prevents silent ppo activity.
	12. Physician has right to terminate indivual payers for breach of terms if not cured in 30 days from notice.
Provider/Hospital Finder	www.humana.com

Humana's Medicare Advantage (formerly Medicare+Choice) Plans

Select Plan for BRAZOS County, Texas

Humana PDP Standard S5884-080
Humana PDP Enhanced S5884-020
Humana PDP Complete S5884-050
HumanaChoicePPO R5826-026
HumanaChoicePPO R5826-040
HumanaChoicePPO R5826-012
Humana Gold Choice PFFS H1804-146

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Guidance when you need it most
Back to Humana.com

Physician Finder Plus
Where to find participating physicians, hospitals, facilities and other health care professionals.

Your Search Results Sorted by Mileage

Order by: Mileage

Coverage Plan: Humana/ChoiceCare Network PPO
Location: 50 miles from College Station, TX 77840
Provider Type: Hospitals
Total Results: 8

Print Friendly Version Refine Search

Physicians and health care professionals, if your information has changed please click here.

Provider Name	Address Information	Miles	Specialty
The Physicians Centre Humana Network	3131 University Dr E Bryan, TX 77802 Phone: (979) 731-3200 County: Brazos	3.0	Hospital
College Station Medical Center Humana and ChoiceCare Networks	1604 Rock Prairie Rd College Station, TX 77845 Phone: (979) 764-5100 County: Brazos	3.1	Hospital
St Joseph Behavioral Health ChoiceCare Network	2010 E Villa Maria Rd Ste C Bryan, TX 77802 Phone: (409) 776-3900 County: Brazos	3.5	Mental Health Hospital
St Joseph Regional Health Center ChoiceCare Network	2801 Franciscan Dr Bryan, TX 77802 Phone: (979) 776-3777 County: Brazos	3.6	Hospital
Grimes - St Joseph Health Center ChoiceCare Network	210 S Judson St Navasota, TX 77868 Phone: (409) 825-6585 County: Grimes	22.9	Hospital
Burleson St Joseph Health Center ChoiceCare Network	1101 Woodson Dr Caldwell, TX 77836 Phone: (979) 567-3245 County: Burleson	27.6	Hospital
Trinity Community Medical Center of Brenham ChoiceCare Network	700 Medical Pkwy Brenham, TX 77833 Phone: (979) 836-6173 County: Washington	32.4	Hospital
Central Texas Hospital ChoiceCare Network	806 N Crockett Ave Cameron, TX 76520 Phone: (254) 697-6591 County: Milam	48.0	Hospital

HUMANA. Physician Quick Reference Guide

E-capabilities

www.humana.com

Available at www.humana.com:

- Eligibility and benefits inquiry (includes out-of-pocket accumulators)
- Certificate of coverage
- Referral/authorization submission, modification and inquiry
- View and submit outpatient service authorization (PPO)
- Claims status inquiry
- Remittance advice inquiry and download
- Fee schedule inquiry
- Online claims submission (via ZirMed)
- Message Center
- Service Fund view and download
- Administration manuals
- Provider directories
- Referral summary report
- Similar features are offered at www.availity.com.

Humana	www.humana.com (800) 448-6262	View Humana information
Availity	www.availity.com (800) 282-4548	Same as Humana information
Passport	www.passporthealth.com (888) 661-5657	eligibility inquiry • claim status
ZirMed	www.zirmed.com (877) 494-7633	eligibility inquiry • claims submission
Nebo	www.nebo.com (866) 810-0000	eligibility inquiry • claims submission

Frequently Used Phone Numbers

Customer Service/Provider Service		
Humana Health Plan		(800) 448-6262
Humana Health Plan (Medicare/Medicaid)		(800) 457-4708
Humana Insurance Co. (formerly Employers Health Insurance)		(800) 558-4444
Humana Health Plan of Ohio (formerly ChoiceCare)		(800) 575-2333
Precertification/Preadmission Review/IVR		
Humana Health Plan		(800) 523-0023
Humana Insurance Co. (formerly Employers Health Insurance)		(800) 647-4477 or (513) 784-5314
Referral Services		
P.O. Box 400029	phone	(800) 626-2698
San Antonio, TX 78229-0029	fax	(800) 266-3022
Web-based Services		
Connectivity Issues		(800) 448-6262
Deployment issues (registration, training)		deployment@humana.com
Humana Web Specialist		(877) 845-3480

Humana's Automated Line: (800) 4-HUMANA (800-448-6262)
Available 24 hours a day, seven days a week for eligibility inquiry, limited benefits and copayments, claim status inquiry, referral inquiry and fax-back confirmation.

Preadmissions: (800) 523-0023
Available for preadmission notification, non-HMO precertification and status inquiry on existing cases.

Information to have ready: Your nine-digit tax ID number, nine-digit member ID, patient's date of birth and date of service. For preadmission cases, you will need the nine-digit tax ID of the servicing facility, diagnosis code and procedure code (if available).

Clearinghouses

Availity	www.availity.com	(800) 282-4548
ENS	www.enshealth.com	(800) 341-6141
McKesson	www.mckesson.com	(800) 482-3784
Medifax	www.medifax.com	(800) 819-5003
Nebo	www.nebo.com	(866) 810-0000
NDC	www.ndchealth.com	(800) 778-6711
Per Se Technologies	www.per-se.com	(877) 737-3773
Proxymed	www.proxymed.com	(800) 882-0802
SSI Group	www.ssigroup.com	(800) 881-2739
THIN	www.thinedi.com	(972) 766-5480
WebMD	www.webmd.com	(877) 469-3623
ZirMed	www.zirmed.com	(877) 494-7633

Claims & Encounter Submissions

Claims	Humana Claims Office
Humana Claims	P.O. Box 14601 Lexington, KY 40512-4601
Humana of Ohio (formerly ChoiceCare) Claims	P.O. Box 14600 Lexington, KY 40512-4600
Dental	P.O. Box 14611 Lexington, KY 40512-4611
Encounters	Humana Claims Office
Humana Encounters	P.O. Box 14605 Lexington, KY 40512-4605

Payer IDs

Preferred Connectivity Solution	www.availity.com
Standard Payer Codes	
Claims	61101
Encounters	61102
Clearinghouses with Standard Payer Codes	ENS • NDC • ProxyMed • SSI • THIN • WebMD • ZirMed
Payer Code Exceptions	
Per Se Technologies	1359000
McKesson	2449

Please be aware that some electronic claims clearinghouses and vendors charge a service fee. For more information, please call your clearinghouse/vendor or assigned provider connectivity consultant or send e-mail to deployment@humana.com.

E-capabilities - Helpful Hints

- Make sure you are using the correct payer code for claims and encounters.
- If Humana did not receive your claim, contact your clearinghouse.
- For information on a no-cost, multipayer EDI solution, please log on to www.availity.com or contact your provider connectivity consultant at deployment@humana.com.
- For Availity technical assistance, please call (800) 282-4548.
- For Humana technical assistance, please call (800) 448-6262.

Updated: January 2005

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Preauthorization and Notification List

Effective Date: 2/1/06

The attached document provides a list of services requiring preauthorization or requesting notification.

Please note: investigational and experimental procedures are not usually covered benefits. Please consult the member's certification or contact Humana for confirmation of coverage.

It is important to understand that some employer groups for whom we provide administrative services only (self -insured, employer-sponsored programs) may customize their plans with different requirements. Thus, there are exceptions to this list. Since a single document cannot reflect all possible exceptions, we recommend that an individual practitioner making a specific request for services verify benefits and authorization requirements prior to providing services. This list is subject to change with notification.

Guidance to our members can best be achieved when we are notified of specific services so that we can provide information on benefits and condition support. To achieve this goal, we have several items for which we are requesting notification; please note these items on the document.

Notes:

1. Louisiana clients, please contact Humana for preauthorization requirements as your list is specific to your plans.
2. This updated Preauthorization and Notification List is not a comprehensive list for HMO members. Providers should continue to contact Humana to determine whether preauthorization or referrals are needed for all Humana HMO membership.

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Preauthorization and Notification List

CATEGORY	DETAILS	Commercial
Inpatient Admissions	Acute Hospital	X
	Long Term Acute Care	X
	Mental Health	X
	Partial Hosp/Residential Treatment	X
	Rehab Facilities	X
	Skilled Nursing Facilities	X
DME	Any item greater than $750.00	X
	Bone Growth Stimulators	X
	CPAP/Bi Pap	X
	CPM Machines	X
	Cranial Orthotics	X
	Electric Beds	X
	Electric Wheelchairs/Scooters	X
	High Frequency Chest Compression Vests	X
	Neuromuscular Stimulators	X
	Prosthetics	X
Plastic Surgery/Cosmetic	Abdominoplasty	X
	Blepharoplasty	X
	Breast Procedures	X
	Otoplasty	X
	Penile Implant	X
	Rhinoplasty	X
	Septoplasty	X
Other Services	AICD, Automatic Implantable Cardioverter Defibrillators	X
	Obesity Surgeries	X
	Oral Surgeries	X
	Transplant Surgeries	X
	UPPP	X
	Ventricular Assist Devices	X
	Varicose Vein: Surgical Treatment and Sclerotherapy	X
	Facet Injections	X
	Home Health	X
	Hyperbaric Therapy	X
	Infertility testing and treatment	X
Radiology: Outpatient Imaging	CT Scan	X
	MRA	X
	MRI	X
	Nuclear Stress Test	X
	PET Scan	X
	SPECT Scan	X
Non-Participating Provider/ Facility Requests		Notification Requested
Maternity	Routine Maternity Care	Notification Requested

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Pharmacy Preauthorization and Notification List

For these drugs when delivered in the provider office, clinic or home.			
Class	**Brand Name**	**Generic Name**	**Commercial**
Erythropoetin	Aranesp	darbepoetin alfa	X
	Epogen	epoetin alfa	X
	Procrit	epoetin alfa	X
Colony Stimulating Factor	Neulasta	pegfilgrastim	X
Growth Hormone	Genitropin	somatropin	X
	Nutropin	somatropin	X
	Nutropin AQ	somatropin	X
	Humatrope	somatropin	X
	Tev-tropin	somatropin	X
	Serostim	somatropin	X
	Siazen	somatropin	X
	Norditropin	somatropin	X
Growth Hormone Receptor Antag	Somavert	pegvisomant	X
Intravenous Immune Globulin	1 gm Injection		X
	10 mg Injection		X
Prostate Cancer	Lupron	leuprolide acetate	X
	Lupron Depot	leuprolide acetate depot	X
	Eligard	leuprolide acetate	X
	Trelstar	triptorelin pamoate	X
Multiple Sclerosis	Avonex	interferon beta-1a	X
	Betaseron	interferon beta-1b	X
	Copaxone	glatiramer acetate	X
	Rebif	interferon beta-1a	X
Hepatitis C Treatment	Pegasys	peginterferon	X
	Peg-Intron	peginterferon	X
Rheumatoid Arthritis	Enbrel	etanercept	X
	Humira	adalimumab	X
	Kineret	anakinra	X
	Remicade	infliximab	X
Chemotherapy	Rituxan	rituximab	X
RSV Prophylaxis	Synagis	palivizumab	X

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Guidance when you need it most

Provider Appeal Process

This document provides instructions for Medical Doctors (MD) and Doctors of Osteopathy (DO) to appeal post-service adverse determinations related to medical necessity, experimental, or investigational procedures/services. This process does not supersede any state or federal process available to providers.

Humana strives to resolve provider issues through the customer service review process. If the issue cannot be resolved to the provider's satisfaction, the provider has the option to appeal the decision. Humana offers a two level appeal process. The first level is an internal review. If the internal appeal is not resolved to the satisfaction of the provider, a second level external review is offered.

Pre-service appeals: Providers have the right to file an appeal of an adverse determination with respect to payment by Humana if they are appealing on a member's behalf. For urgent pre-service appeals, the provider will be automatically assumed to be acting as the representative of the member. For other pre-service appeals, the provider must obtain a power of attorney or other written authorization from the member.

Post-service appeals: Prior to requesting a post-service appeal of an adverse payment determination, the provider must use best efforts to obtain a power of attorney or other written authorization from the member.

Note: Providers are not permitted to pursue a post-service appeal when the member has filed an appeal on his or her own behalf or a pre-service appeal was filed with respect to the same service.

External review: Upon exhaustion of the pre-service or post-service appeal, the provider may request an external review assuming the cost of the services at issue exceeds any threshold amount the member would be required to meet in order to appeal. Listed below are the applicable states and threshold amounts:

State	Product	Threshold amount
AR	PPO, Individual	>$500.00
GA	HMO, PPO, Individual	>$500.00 member liability
NV	PPO	>$500.00 member liability
OH	HMO, PPO, Individual	>$500.00 member liability
SC	PPO, Individual	>$500.00 member liability
VA	PPO, Individual	>$300.00 member liability
WI	HMO, PPO, Individual	>$268.00

This process will not be available for services rendered to members of a self-funded group, if the group does not elect to adopt Humana's external review process.

First-level appeal process

The provider (MD or DO) may submit an appeal for a post-service adverse determination related to medical necessity, experimental, or investigational procedure/service within 180 calendar days of the initial adverse determination.

The appeal will be reviewed by a Humana Medical Director not involved in the initial determination. The reviewer will be of the same specialty but not necessarily the same sub-specialty as the appealing provider. Same specialty is defined as:

- a physician with similar credentials and licensure as those who typically treat the condition or health problem or
- a physician who has experience treating the same problems as those in question and has experience treating complications of those problems.

If Humana does not have a Medical Director meeting the qualifications of same specialty, the first-level appeal is bypassed and the request will automatically proceed to the second-level appeal process and sent for external review.

Upon receipt of the appeal request, Humana will issue an acknowledgement letter within 10 business days. If complete documentation is not submitted with the appeal, Humana will request the necessary documentation to complete the review. This may include medical records, operative notes, and/or other relevant documents. Regardless of documentation received, a decision will be made within 60 calendar days of the initial request utilizing available information.

The provider (MD or DO) should use the Provider Appeal Request Form or a letter providing all of the information included in the Provider Appeal Request Form to initiate the appeal.

Note: The appeal may be delayed if the Provider Appeal Request Form or letter providing all the information is not submitted to the P.O. Box identified on the attached forms.

Second-level appeal process

Upon exhaustion of the internal appeal process and provided the cost of the service being appealed exceeds any threshold amount the member would be required to satisfy in order to appeal; the provider may seek external review. Independent Review Organizations (IRO) will be utilized to conduct a de novo review of the case. For appeal issues other than medical necessity, experimental, and investigational, the member's benefit plan document will control.

The request must be submitted within 60 calendar days of the first-level appeal denial. Humana will attempt to obtain all necessary documentation to review the case if not submitted with the original request. No later than 10 business days after receipt of the requested information at the appropriate address, Humana will submit the request to the IRO for review. The IRO will make a decision within 30 calendar days and notify Humana of their decision. Upon receipt of the IRO's decision, Humana will issue a resolution letter within 5 business days to the appealing provider and member. Second-level appeal decisions are binding for the Provider and Humana.

Note: The appeal may be delayed if the Provider Appeal Request Form or letter providing all the information is not submitted to the P.O. Box identified on the attached forms.

The Provider Appeal Process outlined above was created to review adverse determinations for medical necessity, investigational, or experimental procedures/services provided by Medical Doctors or Doctors of Osteopathy.

For appeals meeting the criteria outlined above, send your appeal request form to:
Humana Inc.
P.O. Box 14615
Lexington, KY 40512-4615

If you are a provider in Arizona, Georgia, Kentucky, or Texas, send your grievance or appeal request to:
Humana Inc.
P.O. Box 14618
Lexington, KY 40512-4615

If you are a non-participating provider appealing services rendered to a Medicare member, send your appeal request to:
Humana Inc.
P.O. Box 14546
Louisville, KY 40512-4546

For all other issues not covered by this or a state/federal defined process, send correspondence to:
Humana Inc.
P.O. Box 14601
Lexington, KY 40512-4601

HUMANA.
Guidance when you need it most

Provider Appeal Request Form

All requests for a provider first-level appeal should include:

1. A completed provider appeal request form initiating the appeal or a letter of appeal requesting review, including all of the information on this form, and indicating the reason for the appeal.
2. A copy of the original claim and explanation of remittance (EOR) or an explanation of benefits (EOB), if applicable.
3. Supporting documentation for the appeal such as medical records, operative report, and a narrative description of the appeal.

Submit the request and supporting documentation to:

Humana Inc.
P.O. Box 14615
Lexington, KY 40512-4615

Treating provider name (as submitted on claim)	Tax Identification Number (as submitted on claim)	
Telephone Number Office ( ) ext.	Fax Number Office ( )	
Contact Name	Contact Telephone Number	Contact e-Mail
Provider Signature		Date
Member Name	Member Date of Birth	
Member ID Number	Member Group Number	
Member Address (Street, City, State, Zip Code)		
Claim Number		
Date(s) of Service		
Procedure(s) or Type of Service(s)		
Reason for Appeal		

In the case of a state/federal internal review process available to the provider without the member's consent and different from this process, only the state/federal mandated process will be utilized.

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Guidance when you need it most

Provider Medical Necessity/Experimental/Investigational External Review Request Form

Instructions:

1. Upon completion of the first-level appeal, providers may request a second-level review by providing the information requested below.

2. A copy of Humana's coverage denial letter, medical records, as well as all other information the provider wishes to be considered in the review, must be attached to this form. The determination of the independent review organization will be based upon the information submitted and the terms and conditions of the members' benefit plan document.

3. Send this completed form and all other information to:

   Humana Inc.
   P.O. Box 14615
   Lexington, KY 40512-4615

Provider Information

Treating provider name (as submitted on claim)	Tax Identification Number (as submitted on claim)	
Telephone Number Office ( ) ext.	Fax Number Office ( )	
Contact Name	Contact Telephone Number	Contact e-Mail
Provider Signature		Date

Member Information

Member Name	Member Date of Birth
Member ID Number	Member Group Number
Member Address (Street, City, State, Zip Code)	

External Review Information

Reason for External Review:	
Date of Service(s):	Case Number (indicated on denial letter):
Procedure(s) or Type of Service(s)	
Cost of Denied Service(s) $	

The decision of the IRO is final and binding to Humana and the provider and/or provider group only with respect to the specific case being reviewed by the IRO.

In the case of a state/federal external review process available to the provider without the member's consent and different from this process, only the state/federal mandated process will be utilized.