

CHECK LIST
SOUTH DAKOTA
state employee
benefits program
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External Review Application

What you need to send in when applying for an external review

- Completed request form.
- Photocopy of insurance identification card.
- Letter from Director of Employee Benefits or Utilization Review Company that states their decision is final and that all internal review procedures were exhausted or that they waive the requirements to exhaust all internal review procedures.

If you have any questions about completing the request or if you are requesting an expedited external review contact the Bureau of Human Resources at 605.773.3148 before sending your paperwork for the quickest way to submit the request.

South Dakota Division of Insurance
Attn: External Review
124 S. Euclid Avenue
Pierre, SD 57501
Phone: 605.773.3563
Fax: 605.773.5369

External Review Request Form

South Dakota Division of Insurance
124 S. Euclid Avenue
Pierre, SD 57501-3185
Phone: 605.773.3563, Fax: 605.773.5369
www.state.sd.us/insurance

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Division of Insurance **within FOUR MONTHS** after receipt of notice of an adverse determination or final determination and you have exhausted the internal grievance process. If this is a request for an expedited review please contact the Bureau of Human Resources at 605.773.3148.

Applicant Name

Covered Person Provider Authorized Representative

Date of request

Type of request Standard Expedited

Covered Person / Patient Information

Name				
Address				
City	State	ZIP		
Telephone	Fax			
E-mail				

Insurance Company

Name	SD State Employee Health Plan	Individual or Group Plan	Self-funded group		
Covered Persons Insurance ID					
Insurance Claim/Reference #					
Address	500 E. Capitol Ave				
City	Pierre	State	SD	ZIP	57501
Insurer contact	Desirae Van Roekel				
Telephone	605.773.3148	Fax	605.773.6840		
E-mail	BHR.memberbenefits@state.sd.us				

Employer Information

Name	State of South Dakota	Phone	605.773.3148	
Is the health coverage you have through your employer a self-funded plan? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If you are not certain please check with your employer.				

Health Care Provider Information

Name				
Address				
City	State	ZIP		
Contact Person				
Telephone	Fax			
Medical Record #				

