External Review Form

Patient Name:

Provider/Facility under review	Health Carrier/Entities involved in previous determinations
	No Organizational COI: *Date:*

IF YOU HAVE A POTENTIAL CONFLICT OF INTEREST, DO NOT PERFORM THE REVIEW. IMMEDIATELY NOTIFY CIMRO AT PEERREVIEW@CIMRO.COM OR 800.635.9407.

Conflict of Interest includes, but is not limited to:

- An ownership interest of greater than 5% between any affected parties
- A material professional, familial, or financial relationship with the referring entity, the insurance issuer or group health plan/carrier that is the subject of the review; covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director, or management employee of the insurance issuer; any group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group or independent practice association recommending the health service or treatment under review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended
- A management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy, and quality management committees
- Staff privileges at a facility where the recommended health care service or treatment would be provided if the insurance issuer or group health plan previous non-certification is reversed
- A direct or indirect financial incentive for a particular determination
- Incentives to promote the use of a certain product or service
- Any prior involvement in the specific case under review

PR ATTESTATION

****** THE REVIEWER DEEMS NO COI EXISTS BY SIGNING THIS ATTESTATION******

I certify that I have the current unrestricted scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review. I have current, relevant experience and/or knowledge to render a determination for the case under review. I have provided direct patient care for ______ years, and my most recent relevant direct patient care experience was in the year _______. I am not bound by any decisions or conclusions reached during previous reviews of this case. I do not accept compensation for review activities that is dependent in any way on the outcome of a case. I do not have a Conflict of Interest with any aspect of this case. I attest to no delegation of the review rendered.

PR ATTESTATION SIGNATURE: ________________________ **DATE:** ____________

This document requires a handwritten or electronic signature.

Certification and acceptance statements signed by you are on file at CIMRO regarding your review and acceptance of CIMRO's Confidentiality-Security Policy, Conflict of Interest Policy, and Code of Business Conduct requirements: 1) to emphasize the confidential nature of the services provided by CIMRO, 2) to emphasize the importance of identification and disclosure of conflict of interest, and 3) as part of our ongoing commitment and belief that compliance with these is a shared responsibility. An annual reminder is also published in *Peer Review eNews.*

urac ACCREDITED Independent Review Organization: External Review Expires 09/01/2024