



**Department of Consumer and Business Services**  
**Insurance Division — Consumer Advocacy – 2**  
P.O. Box 14480  
Salem, Oregon 97309-0405  
Phone: 503-947-7984, Fax: 503-378-4351  
888-877-4894 (toll free)  
350 Winter St. NE, Salem, Oregon  
www.insurance.oregon.gov

**External Review  
Referral**

**For use by insurance companies only.**

Please call the external-review message line, 503-947-7276, if faxing an external-review request to the Insurance Division. Tell us the insurer name and the date and time the fax was sent.

Date of request: \_\_\_\_\_

Type of request:  Regular  Expedited

**Insurer**

Name: \_\_\_\_\_

NAIC no.: \_\_\_\_\_

Street address or P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Insurer contact person: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Patient**

Name: \_\_\_\_\_

Street address or P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Date and time insurer received request for external review from enrollee:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Attorney or representative**

If the patient has representation, please list name, phone number, e-mail address, and street address of attorney or representative.

Name: \_\_\_\_\_

Street address or P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

