DISCLOSURE FOR CONFLICTS OF INTEREST EVALUATION

The following information is provided to ensure that the independent review organization (IRO) assigned to conduct my external review does not have a conflict of interest:

Member name:	
Appointed representative, if any:	
Member's immediate family members (spouse, reciprocal beneficiary, civil union partner, parents, children):	
Health plan:	Hawaii Medical Service Association (HMSA)
If your health care coverage is provided by your employer, name of employer:	
If you are a union member, name of union and trustees (include additional sheet as needed):	
If you are an employee of the state, county, or legislature, the EUTF and its trustees (include additional sheet as needed):	
Plan employees (i.e., benefit plan administrator and staff, if any):	
Health care providers who are or have treated you for the condition that is the subject of the external review, and their medical group(s):	
Health care provider and facility where requested health care service or treatment would be provided:	
Developer or manufacturer of the principal drug, device, procedure, or other therapy that is the subject of the external review:	

I certify that the information that I have provided is true and correct.

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(Signature of Member or Member's Representative)

Date: ________________________