[Insurers may insert an address block directing providers to transmit this form to a specific location.]

TREATING PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEW

A member who is denied a requested service may receive an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process "is likely to cause a significant negative change in the member's medical condition at issue that is subject to the appeal."
An expedited appeal cannot be requested for a service that has already been performed.

PROVIDER INFORMATION

Treating Physician/Provider_____
Phone # _____ FAX # _____
Email: _____
Address _____
City _____ State _____ Zip Code _____

PATIENT INFORMATION

Patient's Name _____ Member ID # _____
Phone # _____ Email: _____
Address _____
City_____ State _____ Zip Code _____

INSURER INFORMATION

Insurer Name _____
Phone # _____
Address _____
City_____ State _____ Zip Code _____

- What denied service is being appealed? _____
_____

- Explain why you believe the member needs the requested service and why the time for the standard appeal process will harm the patient.
_____
_____
_____
_____

Attach additional sheets if needed, and include: ☐ Medical records ☐ Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance and Financial Institutions Consumer Services number (602) 364-2499. You may also call [name of insurer] at _____.

I certify, as the patient's treating provider, that delaying the member's care for the time period needed for the informal reconsideration and formal appeal processes is likely to cause a significant negative change in the member's medical condition at issue.

Treating Provider Signature _____ Date _____