Health Care Appeals
Arizona Department of Insurance and Financial Institutions
100 North 15th Avenue, Suite 261, Phoenix, AZ 85007-2630
Phone: (602) 364-2399 | Web: https://difi.az.gov

STATE OF ARIZONA HEALTH CARE APPEALS TRANSMITTAL FORM

FOR INSURER USE ONLY

1. Are you requesting an **EXPEDITED** External Independent Review? ☐ **Yes** ☐ **No**
2. **Was the denial based on:** ☐ **medical necessity** ☐ **coverage**
3. **Attach the following documents:**
   - **A.** Copy of the insured's complete policy, certificate, evidence of coverage or similar document
   - **B.** All medical records and supporting documentation used to render the decision
   - **C.** Summary description of the applicable issue(s) being appealed
   - **D.** Copies of the utilization review agent's or insurer's previous denials
   - **E.** The utilization review agent's or insurer's criteria used and the clinical reasons for the decision, including the relevant portions of the utilization review agent's utilization review plan
   - **F.** The member's or provider's current and previous appeal requests, and all related correspondence between the member and insurer, including required acknowledgment letters
4. **Insured Member's Information:** Name _____
   Patient's name _____ Under 18? ☐
   Mailing Address _____
   City _____ State _____ Zip Code _____
   Telephone # (_____)_____ Member I.D. # _____
   Email _____
5. **Member's coverage is:**
   Group ☐ Individual ☐ HMO ☐ PPO ☐ POS ☐ On Exchange ☐ Off Exchange ☐
6. **Insurer's Information:** Company Name _____
   Insurer's NAIC # _____
   Insurer's Street Address _____
   City _____ State _____ Zip Code _____
   Telephone _____ FAX # (_____)_____
   Contact Person Name _____ Phone # (_____)_____
   Contact Person Email _____
7. **Treating Provider:** (List multiple providers on reverse)
   Name _____ Specialty _____
   Mailing Address _____
   City _____ State _____ Zip Code _____
   Provider's Telephone # (_____)_____FAX # (_____)_____
   Email: _____
8. **External Review requested by:** member ☐ insurer ☐ UR agent ☐ Provider ☐
   Date external review requested _____ Date of level 2 decision _____
9. **Completed by**_____ _____
   Print Name & Title Date

Additional Treating Providers: (continued from page one)

Name ____ Specialty _________________
Mailing Address ____
City ____ State _______ Zip Code ____________
Provider's Telephone # (_____)____________________FAX # (_____)_____________________
Email: _______________________________________

Name ____ Specialty _________________
Mailing Address ____
City ____ State _______ Zip Code ____________
Provider's Telephone # (_____)____________________FAX # (_____)_____________________
Email: _______________________________________

Name ____ Specialty _________________
Mailing Address ____
City ____ State _______ Zip Code ____________
Provider's Telephone # (_____)____________________FAX # (_____)_____________________
Email: _______________________________________

Name ____ Specialty _________________
Mailing Address ____
City ____ State _______ Zip Code ____________
Provider's Telephone # (_____)____________________FAX # (_____)_____________________
Email: _______________________________________

Name ____ Specialty _________________
Mailing Address ____
City ____ State _______ Zip Code ____________
Provider's Telephone # (_____)____________________FAX # (_____)_____________________
Email: _______________________________________