AZ Health Care Insurer Appeals Process Information Packet

Ameritas Life Insurance Corp.

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL ADVERSE DETERMINATIONS THAT WE MAKE ABOUT YOUR HEALTH CARE.

IMPORTANT: THE STANDARD APPEAL PROCESS FOR ALL PLANS MUST INCLUDE AN INITIAL APPEAL LEVEL OF REVIEW. FOR SOME PLANS WE MAY ELECT TO OFFER A SECOND INTERNAL LEVEL OF REVIEW CALLED A VOLUNTARY INTERNAL APPEAL. THE VOLUNTARY INTERNAL APPEAL, AND ANY REFERENCE TO THE VOLUNTARY INTERNAL APPEAL IN THIS PACKET, DOES APPLY TO YOUR PLAN.

We must send you a copy of this information packet when you first receive your policy, at the request of you or your treating provider, and provide access to a copy of this health care appeals information packet on our website Ameritas.com. When your insurance coverage is renewed, we will send you a reminder that you can request another copy of this packet. Just call our customer/member services number at on the CONTACT US page in this packet to request an additional copy.

WHICH DISPUTES ARE ELIGIBLE FOR ARIZONA'S HEALTH CARE APPEALS PROCESS?

You can file an appeal when you are notified by us of an Adverse Determination, which means that a requested service or a claim for service or a denial, reduction, or termination of service, in whole or in part is:

- Not medically necessary or appropriate, including the health care setting, level of care or effectiveness of a treatment or service.
- Experimental or investigational.
- Not a covered service.

An Adverse Determination also includes a cancellation of the policy back to the effective date due to a reason other than failure to pay premiums, known as a rescission of coverage.

Examples of disputes that are not eligible for Arizona's Health Care Appeals process include:

- You disagree with our determination as to the amount we paid for a service or treatment.
- You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
- You disagree with the amount of your cost-share (Co-payments and co-insurance) or how we have applied your claims or services to your plan deductible.

If you disagree with a decision we made that is not appealable, contact us at the number on the CONTACT US page in this packet.

WHO CAN FILE A HEALTH CARE APPEAL OR REPRESENT A MEMBER?

You or your treating provider on your behalf can file an appeal. The following authorized representatives can also file an appeal on your behalf:

- A parent or legal guardian.
- A surrogate who is authorized to make health care decisions for the member through a power of attorney, a court order or the provisions of A.R.S. § 36-3231.
- An agent who is an adult and who has the authority to make health care treatment decisions for the member pursuant to a health care power of attorney.

If you are the member and want to file a health care appeal, you can work with your treating provider to help you with information you need to support your appeal. In Arizona, the majority of health care appeals are filed by treating providers.

TOOLS FOR FILING A HEALTH CARE APPEAL

In this packet, you will find forms that you can use for your appeal. The Arizona Department of Insurance and Financial Institutions ("AZ DIFI") developed these forms to help consumers file a health care appeal. You are **not** required to use them and we **cannot** reject your appeal if you do not use them. To file an appeal, you can call us or send us a request in writing. If you need help in filing an appeal, or you have questions about the appeals process, contact us at the Phone number on your ID card or listed on the CONTACT US page in this packet.

If you have general questions about health care appeals, you can contact the AZ DIFI's Consumer Services Section at (602) 364-2499 or visit the AZ DIFI website at www/difi.az.gov.

DESCRIPTION OF THE APPEALS PROCESS

There are two types of appeal time frames: an expedited appeal for urgent matters, and a standard appeal. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Appeals are categorized as either Medical Necessity or Coverage. The designation will affect how the case is handled by us and by the AZ DIFI, as well as the rights you have once the health care appeals process has been completed.

STANDARD VS EXPEDITED TIME FRAMES: IS IT URGENT?

Generally, a standard appeal for a service not yet provided will be completed within 30 days**.**

If your appeal is urgent, your treating physician must certify and provide supporting documentation to us that the time frame for a standard appeal review would cause a significant negative change in your condition. There is a provider certification form at the end of this packet, but it is not required to be used. Your provider could also send a written request or create a form with similar information. Your treating provider must send the certification and documentation to us using the information on the CONTACT US page in this packet**.**

Adverse Determinations Eligible for Expedited Appeal Process

The following is a non-exhaustive list of Adverse Determinations that may be expedited with certification from your provider**:**

- A denial of a health care service as experimental or investigational.
- A denial of a health care service for which a member has received emergency services but has not been discharged.
- A denial, reduction, or termination of coverage for an admission.
- Availability of care.
- A continued stay for a course of treatment before the end of the period of time or number of treatments recommended by the treating provider.
- A prior authorization denial.

If you already received the service, or it is an issue of policy rescission, it **cannot** be expedited.

GENERAL APPEALS PROCESS INFORMATION

- Your plan may or may not offer a second internal level of review called the Voluntary Internal Appeal. The first page of this packet indicates whether the Voluntary Internal Appeal applies to your plan.

- You have two years from the date of an Adverse Determination to begin the health care appeals process.

- Requests for all health care appeal levels are to be sent directly to us using the information on the CONTACT US page in this packet.

- An appeal must first go through the Initial Appeal level and, if applicable, the Voluntary Internal Appeal level, or the internal level(s) of review must be waived or deemed exhausted, before seeking an External Independent Review, except that you can simultaneously initiate an Expedited External Independent Review at any internal level of review.

- The Initial Appeal and Voluntary Internal Appeal, if applicable, and the Expedited Medical Review and Expedited Appeal levels of review are completed by us. For the External Independent Review and Expedited External Independent Review levels, we send the appeal to the AZ DIFI.

- At any time we may waive the internal levels of review and move an appeal to the External Independent Review level.

- There is no minimum dollar amount for the value of a claim or service for it to be eligible for the health care appeals process.

- There is no fee to you or your provider for any level of appeal.

- It is important to pay attention to deadlines at each level of review.

- For group and grandfathered individual plans that elect to offer a Voluntary Internal Appeal level, there are three standard appeal levels, and for all plans, there are three expedited appeal levels:

	Expedited Appeals (for urgently needed services you have not yet received)	**Standard Appeals** (for non-urgent services or denied claims)
Level 1	Expedited Medical Review	Initial Appeal
Level 2	Expedited Appeal	Voluntary Internal Appeal
Level 3	Expedited External Independent Review	External Independent Review

- If the External Independent Review involves medical necessity, the AZ DIFI selects an Independent Review Organization ("IRO") that is completely independent of us to make the determination. The IRO reviewer will be a provider that typically manages the condition that is the subject of the appeal.

- If the appeal involves whether a treatment or service is covered in your policy, the AZ DIFI is the external reviewer.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1: Expedited Medical Review

You may obtain Expedited Medical Review of an Adverse Determination for a service that has not already been provided if your treating provider certifies in writing and provides supporting documentation that the time required for a standard appeal is likely to cause a significant negative change in your medical condition. At the end of this packet is a form that your treating provider may use, but that form is **not** required. Your provider could also provide a written request or create a form with similar information. Your treating provider must send the certification and documentation to us using the information on the CONTACT US page in this packet.

We have 72 hours after we receive the request to decide whether we should change our determination and authorize your requested service. Within this time frame, we must call and tell you and your treating provider about our determination. We must also send you a written determination.

If we overturn our determination, we will authorize the service and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited Medical Review and Expedited Appeal levels and send your appeal to the AZ DIFI for Expedited External Independent Review.

Level 2: Expedited Appeal

If we deny your Expedited Medical Review (Level 1), you may request an Expedited Appeal. After you receive our Expedited Medical Review determination, your treating provider must immediately send us a written appeal request using the information in the CONTACT US page in this packet. To help your appeal, your provider should also send us any additional information that the provider hasn't already sent to show why you need the requested service.

We have three business days after we receive the request to decide whether we should change our determination and authorize your requested service. Within this time frame, we must call and tell you and your treating provider about our determination. We must also send you a written determination.

If we overturn our determination, we will authorize the service and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited Appeal level and send your appeal to the AZ DIFI for Expedited External Independent Review.

Level 3: Expedited External Independent Review

Unless we waive the Expedited Medical Review (Level 1) or Expedited Appeal (Level 2) levels of review and send your appeal to the AZ DIFI for Expedited External Independent Review, you may request an Expedited External Independent Review after you have completed an Expedited Medical Review and an Expedited Appeal or simultaneously at any internal level of review. You have four months after you receive a Final Internal Adverse Determination to send to us your written request for Expedited External Independent Review. If the treatment or service is considered experimental or investigational, you can make an oral request if your treating physician certifies in writing that the requested service or treatment would be significantly less effective if not promptly initiated. Send us your request and any additional supporting information using the information in the CONTACT US page in this packet.

There are two types of Expedited External Independent Review (Level 3) depending on the issues in your case: Medical Necessity or Contract Coverage.

(A) Medical necessity

These are cases where we have decided not to authorize a benefit because we determined that the services you or your treating provider are asking for are not medically necessary to treat your condition. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), which is procured by the AZ DIFI and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review. Medical necessity appeals are subject to the following time frames:

- Within one business day of receiving your request, we must:

  1. Send a written acknowledgment of the appeal request to the AZ DIFI, you, and your treating provider.

  2. Send the AZ DIFI all of the following: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our determination; a summary of the applicable issues including a statement of our determination; the criteria used and clinical reasons for our determination; the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the internal levels of review.

- Within two business days of receiving our information, the AZ DIFI must send all the submitted information to the IRO.

- Within 72 hours of receiving the information the IRO must make a determination and send their determination to the AZ DIFI.

- Within one business day of receiving the IRO's determination, the AZ DIFI must send a notice of the determination to you, your treating provider, and us.

The determination (medical necessity): If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our determination to deny the service, the appeal is over. Your only further option is to pursue a claim in Superior Court.

(B) Contract coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the AZ DIFI is the independent reviewer. Contract Coverage appeals are subject to the following time frames:

- Within one business day of receiving your request, we must:

  1. Mail a written acknowledgment of your request to the AZ DIFI, you, and your treating provider.

  2. Send the AZ DIFI all of the following: the request for review, your policy, evidence of coverage or similar document, all medical records and supporting documentation used to render our determination, a summary of the applicable issues including a statement of our determination, the criteria used and any clinical reasons for our determination and the relevant portions of our utilization review guidelines.

- Within two business days of receiving this information, the AZ DIFI must determine whether the service or claim is covered under your insurance policy and send a written notice of their determination to you, your treating provider and us.

Referral to the IRO for contract coverage cases: The AZ DIFI may be unable unable to determine issues of coverage. If this occurs, the AZ DIFI will forward the case to an IRO. The IRO will have 72 hours to make a determination and send it to the AZ DIFI. The AZ DIFI will have one business day after receiving the IRO's determination to send the notice of determination to you, your treating provider and us.

The determination (contract coverage): If the AZ DIFI decides that we should provide the service or pay the claim, we must do so. If either you or we disagree with the AZ DIFI's determination on a coverage issue, you or we may request a hearing with the Arizona Office of Administrative Hearings ("AZ OAH") by sending a request to the AZ DIFIF within 30 days after receiving the AZ DIFI's determination.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Initial Appeal

You can request an Initial Appeal of an Adverse Determination if all of the following apply:

- You have coverage with us,
- We denied your request for a covered service or claim,
- You do not qualify for an expedited appeal, and
- You request an Appeal within two years after the date we make the Adverse Determination.
- You send your request to us using the information in the CONTACT US page in this packet.

At any time we may decide to waive internal review and send your appeal to the AZ DIFI for External Independent Review.

Before we make a Final Internal Adverse Determination that relies on new or additional information generated by us, we must provide you with a copy of the new information along with a reasonable opportunity to respond within the applicable time frames for us to provide a written determination.

Determination and Time Frames:

- For group plans and for grandfathered individual plans that elect to offer a Voluntary Internal appeal level, we have:
    a. 15 days to make a determination for a service not yet provided.
    b. 30 days to make a determination for a service already provided.

We must send you and your treating provider a written determination letter within the time frames above.

If we overturn our determination, we will authorize the service or pay the claim and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process, subject to the following time frames:

- For individual plans, and for group plans that do not elect to offer a voluntary internal appeal level, you have 4 months to request an External Independent Review.

- For group plans and for grandfathered individual plans that elect to offer a voluntary internal appeal level, you have 60 days to request a Voluntary Internal Appeal.

Level 2. Voluntary Internal Appeal

This level of appeal applies only if you have a group plan or grandfathered individual plan, we elect to offer this level of appeal, and you previously completed an Initial Appeal.

You or your treating provider must send us a written request within 60 days of an Initial Appeal determination to tell us you want a Voluntary Internal Appeal (Level 2). To help us make a determination on your appeal, you or your provider should also send us any additional information that you have not already sent to show why we should authorize the requested service or pay the claim. Send your appeal request and information to us using the information in the CONTACT US page in this packet.

At any time we may decide to waive internal review and send your appeal to the AZ DIFI for External Independent Review.

Before we make a Final Internal Adverse Determination that relies on new or additional information generated by us, we must provide you with a copy of the new information along with a reasonable opportunity to respond within the applicable time frames for us to provide a written determination.

Determination and Time Frames:

- We have 15 days to make a determination for a service not yet provided.
- We have 30 days to make a determination for a service already provided.

If we overturn our determination, we will authorize the service or pay the claim and the appeal is over.
If we deny your appeal, our determination will explain the reasons for our determination and the information on which we based our determination. Our determination will also include instructions for the next steps in the appeal process. You have four months to appeal to the External Independent Review Level (3).

Level 3: External Independent Review

You may appeal to the External Independent Review Level 3 only after you have completed the internal level(s) of appeal. You have four months after you receive a Final Internal Adverse Determination to send us your written appeal request and any additional supporting information for External Independent Review. Send your request to us using the information in the CONTACT US page in this packet

This level of review also applies if we elect to waive the internal level(s) of review.
There are two types of External Independent Review (Level 3), depending on the issues in your case: Medical Necessity or Contract Coverage.

(A) Medical necessity
These are cases where we have decided not to authorize a service because we determined that the service you or your treating provider are asking for is not medically necessary to treat your condition. For medical necessity cases, the independent reviewer is a provider retained by an IRO, which is procured by the AZ DIFI and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review. Medical necessity appeals are subject to the following time frames:

- Within five business days of receiving your request, we must:

  1. Mail a written acknowledgment of the request to the AZ DIFI, you, and your treating provider. This acknowledgment must include notice that you have five business days after receiving the notice to submit any additional written evidence to the AZ DIFI for consideration by the external reviewer. The AZ DIFI will forward it to the IRO. If you provide additional information after five business days the IRO may or may not consider it.

  2. Send the AZ DIFI all of the following:
     a. The request for review.
     b. Your policy, evidence of coverage or similar document.
     c. All medical records and supporting documentation used to render our determination(s).
     d. A summary of the applicable issues including a statement of our determination.
     e. The criteria used and clinical reasons for our determination.
     f. The relevant portions of our utilization review guidelines.
     g. The name and credentials of the health care provider who reviewed and upheld the determination(s) at the earlier appeal levels.

- Within five days of receiving our information, the AZ DIFI must send all the submitted information to an IRO.

- Within 21 days of receiving the appeal the IRO must make a written determination and send the determination to the AZ DIFI.

- Within five business days of receiving the IRO's determination, the AZ DIFI must send a written notice of the determination to you, your treating provider, and us.

The determination (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our determination to deny the service or payment, the appeal is over and your only further option is to pursue a claim in Superior Court.

(B) Contract Coverage

These are cases where we have denied coverage because we determined that the requested service is not covered under your insurance policy. For contract coverage cases, the AZ DIFI is the independent reviewer. Contract coverage appeals are subject to the following time frames:

- Within 5 business days of receiving your request, we must:

  1. Send a written acknowledgment of your request to the AZ DIFI, you, and your treating provider.

  2. Send the AZ DIFI: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our determination; a summary of the applicable issues including a statement of our determination; the criteria used and any clinical reasons for our determination; and the relevant portions of our utilization review guidelines; the name and credentials of the health care provider who reviewed and upheld the determination(s) at the initial appeal, and if applicable, the voluntary internal appeal level.

- Within 15 business days of receiving this information, the AZ DIFI must determine whether the service or claim is covered and send a written notice of their determination to you, your treating provider, and us.

Referral to the IRO for Contract Coverage Appeals: The AZ DIFI may be unable to determine issues of coverage. If this occurs, the AZ DIFI will forward your case to an IRO. The IRO will have 21 days to make a determination and send it to the AZ DIFI. The AZ DIFI will have five business days after receiving the IRO's determination to send the notice of determination to you, your treating provider, and us.

The determination (contract coverage): If the Director decides that we should provide the service or pay the claim, we must do so. If either you or we disagree with the AZ DIFI's determination on a coverage issue, you or we may request a hearing with the AZ OAH by sending a request to the AZ DIFI within 30 days after receiving the AZ DIFI's determination.

NOTES ON INDEPENDENT REVIEW ORGANIZATIONS (IROs)

- The AZ DIFI contracts directly with multiple IROs. They each maintain large rosters of many types of specialties of physicians and other licensed health care professionals.

- There is no cost to a member or provider for any part of the appeal process. If the services of an IRO are used, the AZ DIFI selects and pays the IRO, then bills the insurer for reimbursement after the appeal is completed.

- The IRO will check that their reviewer does not have a conflict of interest with the insurer, member, or treating provider, and was not involved in the original denial determination or any previous appeal for the same member.

- There will be no communication with the IRO by you or us. The IRO will complete their review using the documentation in your appeal.

- The IRO reviewer will be a provider who typically manages the condition under review.

- The IRO's determination is binding on all parties. Any further challenges must proceed through Superior Court.

- Even if determined to be medically necessary, neither the IRO, the AZ DIFI, or the AZ OAH can order an insurer to provide or pay for a treatment or service that is excluded in a policy.

OBTAINING MEDICAL RECORDS

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-make unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

DOCUMENTATION FOR AN APPEAL

If you file an appeal, you must include any material justification or documentation. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted.
If your appeal goes to external review, the AZ DIFI may contact you by email from a generic email address (hca@difi.az.gov). If the appeal is already at the External Independent Review level, you will be notified in writing that you have five business days to send any additional information to the AZ DIFI. If you submit anything after the five business days, it does not have to be considered in your appeal.

THE ROLE OF THE ARIZONA DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS (AZ DIFI)

Arizona law requires "any member who files a complaint with the [AZ DIFI] relating to an Adverse Determination to pursue the review process prescribed" by law (A.R.S. §20-2533(F)). This means, that you must pursue the health care appeals process for all appealable adverse determinations before the AZ DIFI can investigate a complaint you may have against our company based on the determination at issue in the appeal.

The appeal process requires the AZ DIFI to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the determinations of insurers.
5. Review determinations of insurers.
6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the AZ OAH.

7. Issue a final administrative determination on coverage issues, including the notice of the right to request a hearing at AZ OAH.

RECIEPT OF DOCUMENTS

Any written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing. "Properly addressed" means your last known mailing address. Any document may alternatively be sent electronically where a member has elected electronic delivery.

You always have the right to contact the Department of Insurance

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261
Phoenix, AZ 85007-2630
(602) 364-2499 or
(800) 325-2548 (In Arizona but outside the Phoenix area)

CONTACT US

AMERITAS LIFE INSURANCE CORP

Ameritas Life Insurance Corp.
800-487-5553

Quality Control 877-897-4328 (Toll-Free)

Ameritas.com

SEND YOUR HEALTH CARE APPEAL TO:

Ameritas Life Insurance Corp.
KRISTI DENISON, MANAGER, QUALITY MANAGEMENT
QUALITY CONTROL
P.O. BOX 82657
LINCOLN, NE 68501-2657
FAX 402-309-2579

SEND YOUR INITIAL APPEAL AND, IF APPLICABLE, VOLUNTARY APPEAL TO:

Standard appeal:
Initial Appeal, or Voluntary Internal, or External Review Send to:
QUALITY CONTROL
P.O. BOX 82657
LINCOLN, NE 68501-2657
FAX 402-309-2579

EXPEDITED appeal:
Initial, or Voluntary Internal, or External Review Send to:
QUALITY CONTROL
P.O. BOX 82657
LINCOLN, NE 68501-2657
FAX 402-309-2579

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial determination.

Insured Member's Name _____ Member ID # _____
Name of representative pursuing appeal, if different from above _____
Mailing Address _____ Phone # _____
City _____ State _____ Zip Code _____

Type of Denial: ☐ Denied Claim ☐ Denied Benefit for Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's determination to deny a benefit for a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What determination are you appealing?

_____
_____
_____

(*Explain what you want your insurer to pay for).*

Explain why you believe the claim or service should be covered:

_____
_____
_____
_____
_____
_____
_____

(Attach additional sheets of paper, if needed).

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548 (outside Metro Phoenix area), or Quality Control at 1-877-897-4328 (Toll-Free).

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: ☐ Medical records ☐ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) ** Also attach the certification from your treating provider if you are seeking expedited review

_____ _____
Signature of insured or authorized representative Date

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the [patient's] medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider _____
Phone # _____ Fax # _____
Address _____
City _____ State _____ Zip Code _____

PATIENT INFORMATION

Patient's Name _____ Member ID # _____
Phone # _____
Address _____
City _____ State _____ Zip Code _____

INSURER INFORMATION

Insurer Name _____
Phone # _____ Fax # _____
Address _____
City _____ State _____ Zip Code _____

- Is the appeal for a service that the patient has already received? ☐ Yes ☐ No
  If "Yes" the patient must pursue the standard appeals process and cannot use the expedited appeals process.
  If "No", continue with this form.
- What service denial is the patient appealing? _____
  _____
- Explain why you believe the patient 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 to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548 (outside Metro Phoenix area), or **Quality Control at** 1-877-897-4328 (Toll-Free).

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the Initial Appeal and Voluntary Internal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature _____ Date _____