Physician Certification - Experimental/Investigational Review

Illinois Department of Insurance

This form is to be completed by the treating provider as a supplement to the Request for External Review form, when the patient has been denied a health care service or course of treatment on the basis that the drug, procedure, therapy or service has been determined to be experimental and/or investigational.

Patient

first name _____ last name _____

Health Care Provider

treating provider name _____

address _____

contact person _____ email _____ phone _____

fax _____

I hereby certify that I am the treating health care provider for the patient named above in this external review and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health carrier's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the patient to obtain the right to an external review of this denial, as treating health care provider I must certify that the patient's medical condition meets certain requirements as shown in this form.

At least one box within item 1 and one box within item 2 must be checked in order to qualify for external review for experimental/investigational denials.

1. The patient has a condition that qualifies under one or more of the following:
Check all that apply. (must check one)

- ☐ standard health care services or treatments have not been effective in improving the patient's condition
- ☐ standard health care services or treatments are not medically appropriate for the patient
- ☐ there is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment

2. Check all that apply. (must check one)

- ☐ The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the patient than any available standard health care services or treatments.
explanation:

- ☐ It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the patient and which has been denied is likely to be more beneficial to the patient than any available health care services or treatment.
explanation:

Physician Certification (con't)

Patient

first name _____ last name _____

Provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (attach additional sheets as necessary)
explanation:

Health Care Provider signature _____ National Provider ID (NPI) _____ date _____

Return this form to:

Illinois Department of Insurance
Office of consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
877-850-4740 toll free phone
217-557-8495 fax
doi.externalreview@illinois.gov