



Health Care Provider Certification

Illinois Department of Insurance

Covered Person/Patient

_____ first name

_____ last name

Health Care Provider

treating

provider name _____

address _____

contact person _____

email _____

phone _____

This form should only be completed if your request qualifies as an Expedited or Experimental/Investigational review of an adverse determination. These are more fully defined below.

Expedited – to qualify as an “expedited” review, the patient must have a medical condition where the timeframe for the completion of a standard review would seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function

Experimental/Investigational - to qualify as an “experimental/investigational” review, the patient must have a medical condition for which 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 a recommended health care service or treatment and would be significantly less effective if not promptly initiated.

The Health Care Provider identified above should complete Section A and/or Section B below.

Section A – Request for Expedited Review

Not available for care or services already received.

Your signature shall constitute certification that your request meets the criteria for an expedited request and must include:

description of patient’s condition: _____

explanation for expedited request: _____

description of how a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function; or in the case of an experimental/investigational adverse determination, how a delay would cause the recommended health care service or treatment to be significantly less effective if not promptly initiated::

Health Care Provider signature

National Provider ID
(NPI)

Date

Section B – Request for Review of Experimental/Investigational Denial

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 covered person to obtain the right to an external review of this denial, as treating health care provider I must certify that the covered person'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 covered person/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 covered person/patient's condition
 - standard health care services or treatments are not medically appropriate for the covered person/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 covered person 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 covered person and which has been denied is likely to be more beneficial to the covered person/patient than any available health care services or treatment.
explanation: _____

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
Insurance.Illinois.gov/ExternalReview