

Pennsylvania External Appeal Request for Authorization

Member Name: _____

ID Number: _____

Request or Case Number: _____

Who is requesting external appeal?

- ☐ I am the member
- ☐ I am the member's Authorized Representative (*please complete the Appointment of Authorized Representative Form*)

How would you like us to contact you? ☐ Phone ☐ Fax ☐ Email ☐ Mail

External Appeal Details

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your case):

1. If your situation is urgent, are you requesting an expedited review?

- ☐ Yes
- ☐ No

If you answer YES, your physician must complete the attached Physician Certification for Expedited Appeals form.

Appointment of Authorized Representative Form

You may represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

Authorized Representative Info

Name: _____

Mailing Address: _____

Daytime Phone: _____

Evening Phone: _____

Email: _____

Fax: _____

I hereby authorize _____ to pursue my external appeal on my behalf.

Signature of Covered Person (or legal representative)

Date

Physician Certification for Expedited Appeals

I hereby certify that I am a treating physician for _____
(hereafter referred to as "the covered person"); and (select all that apply):

I am requesting an expedited internal (first or second level) appeal

- ☐ I certify that adherence to the time frame for conducting a standard internal appeal would, in my professional judgment, subject the covered person to severe pain that cannot be adequately managed without the requested care or treatment; and that, for this reason, the covered person's appeal should be processed on an expedited basis.

I am requesting an expedited external appeal

- ☐ I certify that adherence to the time frame for conducting a standard external appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's external appeal should be processed on an expedited basis.

I am requesting an expedited internal appeal AND expedited external appeal

- ☐ I certify that adherence to the time frame for conducting an expedited internal appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's expedited internal appeal should be conducted simultaneously with an expedited external appeal.

Treating Physician Printed Name

Signature

Date