HEALTH CARE APPEAL REQUEST FORM

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

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 Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny 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 decision are you appealing? _____
_____
_____
(*Explain what you want your insurer to authorize or 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, or [name of insurer] at _____.

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

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 regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1 (800) 325-2548. You may also call [name of insurer] at _____.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal 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 _____

Arizona External Review Request for Authorization

Who is requesting external review?

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

Member Info

Name:
OSC:
Date of Birth:
Mailing Address:
Daytime Phone:
Evening Phone:
Email:
Fax:
Case Number:

Authorized Representative Info

Name:
Mailing Address:
Daytime Phone:
Evening Phone:
Email:
Fax:

Treating Health Care Provider Info

Name:
Mailing Address:
Phone Number:
Email:
Fax:
Contact Person:
Phone Number:

External Review 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):

_____

_

_____

_

_____

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_____

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_____

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Appointment of Authorized Representative

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.

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

_____ _____

Signature of Covered Person (or legal representative) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this appeal request form and consent to the release of medical records.

I _____ hereby request an external review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, health care provider and/or health plan issuer to release all relevant medical or treatment records to the independent review organization and/or the Arizona Department of Insurance. I understand that this authorization permits Oscar to release copies of my identifiable medical records, x-rays or other required medical/dental information to the Independent Review Organization and/or the Arizona Department of Insurance. This authorization includes but is not limited to a release of me medical/dental records, which may include records pertaining to the HIV/AIDS virus, or other sexually transmitted diseases, drug and/or alcohol testing or treatment, mental illness or psychiatric testing or treatment or genetic information, if applicable. I give my specific authorization for these confidential records to be released. I understand that the independent review organization and the Arizona Department of Insurance will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

_____ _____

Signature of Covered Person (or legal representative) Date

**Parent, Guardian, Conservator, or Other - please specify*

Please send this form and a copy of your adverse determination letters to:

Fax:	844-965-9054
Mail:	Oscar Insurance Attn: Arizona Clinical Appeals PO Box 52146 Phoenix, AZ 85072

Be certain to keep copies of this form, your notice of adverse determination, and all documents and correspondence related to this claim.

Can I request copies of information relevant to my claim?

Yes, you may request copies (free of charge) by contacting us at the address noted on this form.