Expedited Appeal Request Form

This Expedited Appeal Request Form must be signed and attested to by the ordering physician or a standard appeal will be performed.

Expedited Appeal Request Form
APPLICANT NAME _____
[ ] Covered person [ ] Patient Provider [ ] Authorized Representative

COVERED PERSON/PATIENT INFORMATION
Covered Person Name: _____
Patient Name: _____
Address:_____
_____
_____
_____
Covered Person Phone #: Home (_____)_____
Work (_____)_____
INSURANCE INFORMATION
Insurer/HMO
Name:_____

Covered Person Insurance
ID#:_____

Insurance Claim/Reference #:
_____
Insurer/HMO Mailing Address:
_____
_____
_____
Insurer Telephone #:
_____

HEALTH CARE PROVIDER INFORMATION
Treating Physician/Health Care Provider:
_____
Address:
_____
_____
_____
_____
Contact Person: _____
Phone: ( )_____
Medical Record #:_____

SUMMARY OF Expedited Appeal Review Request (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier and provide documentation that supports that the time for a standard review would seriously jeopardize the member's life or health or his/her ability to regain function)

_____
_____
_____
_____
_____

My signature attests to the position that the time for a standard review (15 days in this case) would seriously jeopardize the member's health, life or his/her ability to regain function.

_____ Date_____

Ordering Physician Signature