**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**