

STATE OF ARIZONA HEALTH CARE APPEALS TRANSMITTAL FORM

Mail to: *Health Care Appeals, Arizona Department of Insurance, 2910 N. 44th St., Suite 210, Phoenix, AZ 85018-7269*
Questions to: *Health Care Appeals Hotline · Phone: (602) 364-2399 · Fax: (602) 364-2398*

1. Are you requesting an **Expedited** External Independent Review? **Yes** **No**

2. Was the denial based on: **lack of medical necessity?** **a coverage issue?**

3. **Attach legible copies of A through G. For medical necessity cases, attach 2 copies.**

- A. Copy of the insured's complete policy, certificate, evidence of coverage or similar document
- B. All medical records and supporting documentation used to render the decision
- C. Summary description of the applicable issues
- D. A statement of the utilization review agent's or insurer's decision
- E. The utilization review agent's or insurer's criteria used and the clinical reasons for the decision
- F. The relevant portions of the utilization review agent's utilization review plan
- G. The insured's or provider's letter or appeal form requesting the appeal, and all pertinent correspondence between the member/enrollee and the insurer

4. **Insured Member's Information:** Name _____
Patient's name _____ Under 18?
Mailing Address _____
City _____ State _____ Zip Code _____
Telephone # (_____) _____ Member I.D. # _____

5. **Member's coverage is:**
Group Individual HMO PPO POS Self Funded Fully Insured

6. **Insurer's Information:** Company Name _____
Insurer's NAIC # _____
Insurer's Street Address _____
City _____ State _____ Zip Code _____
Telephone # (_____) _____ FAX # (_____) _____
Contact Person Name _____ Phone # (_____) _____

7. **Treating Provider:** (List multiple providers on reverse)
Name _____ Specialty _____
Mailing Address _____
City _____ State _____ Zip Code _____
Provider's Telephone # (_____) _____

8. **Utilization Review Agent:** Name _____
Mailing Address _____
City _____ State _____ Zip Code _____
Telephone # (_____) _____ FAX # (_____) _____

9. **External Review requested by:** insured member insurer UR agent Provider
Date external review requested _____ Date of level 2 decision _____

10. **Decision to deny or not authorize service or claims was made by:**
Insurance Company HMO UR Agent

11. **Completed by** _____
Print Name & Title _____ Signature _____ Date _____