STATE OF ARIZONA HEALTH CARE APPEALS TRANSMITTAL FORM

Is this an Expedited External Independent Review Request? ☐ Yes ☐ No
This case is a denial based on: ☐ lack of medical necessity ☐ a coverage issue

Insured Member's Name ____________________
Mailing Address ____________________
City, State, Zip Code ____________________
Insured's Telephone # ____________ Member I.D. # ____________

Insurer's Name ____________________
Insurer NAIC # ____________________
Insurer's Street Address ____________________
City, State, Zip Code____________________
Telephone # ____________ FAX # ____________
Contact Person Name and Phone no. ____________________

Treating Provider's Name ____________________
Office Address ____________________
Mailing Address, if different than above: ____________________
City, State, Zip Code ____________________
Provider's Telephone # ____________FAX #____________
Treating Provider's Medical Specialty____________________
(If multiple providers, please list other providers on reverse)

Utilization Review Agent ____________________
UR Agent's Street Address ____________________
City, State, Zip Code ____________________
UR Agent Telephone # ____________ FAX # ____________
Contact Person ____________________

External Review requested by: ☐ insured member ☐ insurer ☐ UR Agent ☐ Az D O I
Date External Review requested ____________ Date of Level 2 Decision ____________
Decision to deny or not authorize service or claim was made by:
☐ Insurance Company ☐ Health Care Services Org. ☐ UR Agent
For medical necessity cases: Name(s) and credentials of provider(s) issuing the level 1 & 2 decisions:

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With this form, transmit all items listed below. **For medical necessity cases, submit 2 copies** of all items.

1. Copy of the insured's policy, certificate, evidence of coverage or similar document
2. All medical records
3. Supporting documentation used to render the decision
4. Summary description of the applicable issues
5. A statement of the utilization review agent's or insurer's decision
6. The utilization review agent's or insurer's criteria used and the clinical reasons for the decision
7. The relevant portions of the utilization review agent's utilization review plan
8. The insured's or provider's letter or appeal form requesting the appeal, and all pertinent correspondence between the member/enrollee and the insurer.

Form P-1098 Rev. 10/00