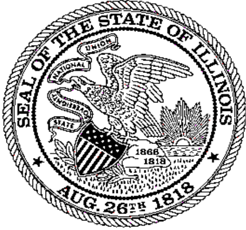

Illinois Department of Insurance

Physician Certification
Experimental/Investigational Review

Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001
877-850-4740 (toll free)
217-557-8495 (fax)
http://insurance.illinois.gov

Updated - 12/11/2017

This form must accompany the "Request for External Review" form

This form must be completed in its entirety. If any fields are not completed upon submission, it will be rejected

This form is to be completed by the treating physician as a supplement to the Request for External Review form when the patient has been denied a health care service or course of treatment on the basis that the drug, procedure, therapy or service has been determined to be experimental and/or investigational.

Patient			
Last	**First**		**MI**
Health Care Provider			
Treating Provider Name			
Address	**City**	**State**	**Zip**
Contact Person	**Phone**		
Email	**Fax**		

1. The patient has a condition that qualifies under one or more of the following: Check all that apply. (must check one)

   Standard health care services or treatments have not been effective in improving the patient's condition

   Standard health care services or treatments are not medically appropriate for the patient

   There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

2. Check all that apply. (must check one)

   The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the patient than any available standard health care services or treatments.

   It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the patient and which has been denied is likely to be more beneficial to the patient than any available health care services or treatment.

Please describe the procedure, treatment or drug that is being denied and why you disagree

I hereby certify that I am the treating health care provider for the patient named above in this external review and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health carrier’s determination that the proposed therapy is experimental and/or investigational. I understand that in order for the patient to obtain the right to an external review of this denial, as the treating provider I must certify that the patient's medical condition meets certain requirements as shown in this form.

Provider Signature ______________________ **National Provider ID** ______________ **Date** ______________

Return this request and supporting attachments to:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL. 62767

Fax Number - 217-557-8495
Message Center Website - https://mc.insurance.illinois.gov/messagecenter.nsf
Email - doi.externalreview@illinois.gov