# Illinois Department of Insurance

## Physician Certification
## Expedited 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 review is NOT available if services have already been provided**
**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 when the patient has a medical condition where the timeframe for completion of an expedited internal appeal (48 hours), a final adverse determination (15-30 days), or a standard external review (21-45 days) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

NOTE: By requesting an expedited external review, you are waiving any available appeal steps and will not have an opportunity to submit additional information after this request.

| **Patient** | | |
|---|---|---|
| **Last** | **First** | **MI** |

| **Health Care Provider** | | | |
|---|---|---|---|
| **Treating Provider Name** | | | |
| **Address** | **City** | **State** | **Zip** |
| **Contact Person** | **Phone** | | |
| **Email** | **Fax** | | |

| **Provide description of patient's condition and explanation for expedited request** |
|---|
| ***REQUIRED*** |

I hereby certify that in my opinion, the above named patient who has received an adverse determination for the medical services that I have recommended as medically necessary requires such review to be provided on an expedited basis because a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function or in the case of an experimental/investigational adverse determination, that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

**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