Health Care Appeals
Arizona Department of Insurance
2910 North 44th Street, Suite 210, Phoenix, Arizona 85018-7269
Phone: (602) 364-2399 | Fax: (602) 364-2398
Web: https://insurance.az.gov

STATE OF ARIZONA HEALTH CARE APPEALS TRANSMITTAL FORM

FOR INSURER USE ONLY

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 # _____
   Contact Person Email _____
7. **Treating Provider:** (List multiple providers on second page)
   Name _____ Specialty _____
   Mailing Address _____
   City _____ State _____ Zip Code _____
   Provider's Telephone # _____ Fax # _____
8. **External Review requested by:** insured member ☐ insurer ☐ UR agent ☐ Provider ☐
   Date external review requested _____ Date of level 2 decision _____
9. **Decision to deny or not authorize service or claims was made by:**
   Insurance Company ☐ HMO ☐ UR Agent ☐
10. **Completed by**_____ _____ _____
    Print Name & Title Signature Date

Additional Treating Providers: (continued from page one)

Name _____ Specialty _____
Mailing Address _____
City _____ State _____ Zip Code _____
Provider's Telephone # _____ Fax # _____

Name _____ Specialty _____
Mailing Address _____
City _____ State _____ Zip Code _____
Provider's Telephone # _____ Fax # _____

Name _____ Specialty _____
Mailing Address _____
City _____ State _____ Zip Code _____
Provider's Telephone # _____ Fax # _____

Name _____ Specialty _____
Mailing Address _____
City _____ State _____ Zip Code _____
Provider's Telephone # _____ Fax # _____

Name _____ Specialty _____
Mailing Address _____
City _____ State _____ Zip Code _____
Provider's Telephone # _____ Fax # _____