TREATING PROVIDER CERTIFICATION FOR EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To be completed by the treating provider)

This form must be completed by the treating provider if your request for an external review involves a denial based on the health plan's determination that the service is experimental and/or investigational. Part 1 and Part 2 must both be completed in order for the Michigan Department of Insurance and Financial Services (DIFS) to accept the external review request.

I hereby certify that I am the treating provider for _____ (patient/covered person's name) and that I have requested the authorization for, or the patient/covered person has received, a drug, device, procedure, or therapy denied for coverage due to the health plan's determination that the service is experimental and/or investigational. I understand that in order for the patient/covered person to obtain the right to an external review of this denial, I must certify that the patient/covered person's medical condition meets certain requirements.

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary.) **PLEASE INCLUDE RELATED MEDICAL RECORDS WITH THIS FORM.**

In my medical opinion as the patient/covered person's treating provider, I hereby certify the following:

PART 1 (REQUIRED)

One or more of the following must apply (check all that apply):

- ☐ Standard health care services or treatments have not been effective in improving the covered person's condition;
- ☐ Standard health care services or treatments are not medically appropriate for the covered person; and/or
- ☐ There is no available standard health care service or treatment covered by the health plan that is more beneficial than the requested or recommended health care service or treatment.

PART 2 (REQUIRED)

One of the following must apply (check all that apply):

- ☐ The health care service or treatment I have recommended and which has been denied is, in my opinion, likely to be more beneficial to the patient/covered person than any available standard health care services or treatments.
- ☐ Scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the patient/covered person is likely to be more beneficial to the patient/covered person than any available standard health care services or treatments. Check only if you are a licensed, board-certified, or board-eligible provider qualified to practice in the area of medicine appropriate to treat the patient/covered person's condition.

_____ _____ _____

Treating Provider's Signature | Print Name of Treating Provider | Date

Treating Provider's Address: _____

_____

Treating Provider's Phone Number: _____ Fax Number: _____

The completed form can be emailed to difs-healthappeal@michigan.gov, FAXED to 517-284-8838, or mailed to: DIFS – Office of General Counsel, Health Care Appeals Section, P.O. Box 30220, Lansing, MI 48909-7720