STATE OF ALASKA
DIVISION OF INSURANCE – External Review
550 W. 7th Avenue, Suite 1560 Anchorage, Alaska 99501-3567
Tel: (907) 269-7900 Fax: (907) 269-7910 TTY/TDD: 711 or (800) 770-8973

Certification of Treating Health Care Provider
External Review Appeal – Experimental or Investigational Treatment

Provider Note:
A covered person/patient can request an external review within 180 days of a health insurance company's a final adverse determination to deny coverage for experimental or investigational treatment, provided the company's internal grievance procedures have been exhausted and other factors are met. The covered person's treating physician must certify that one of the following situations is applicable:

A. standard health care services or treatments have not been effective in improving the condition of the covered person;

B. standard health care services or treatments are not medically appropriate for the covered person; or

C. there is no available standard health care services or treatment covered by the health care insurer that is more beneficial than the recommended or requested health care service or treatment sought.

The request for external review for experimental or investigational treatment must include a written certification from the covered person's treating physician that the:

A. recommended or requested health care service or treatment at issue is likely to be more beneficial to the covered person, in the physician's opinion, than other available standard health care services or treatments; or

B. physician is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, and scientifically valid studies using accepted protocols demonstrate that the health care service or treatment at issue is likely to be more beneficial that other available standard health care services or treatments.

A covered person/patient can request an expedited external review when a health insurance company has denied coverage for a prospective experimental or investigational treatment if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

ALASKA DIVISION OF INSURANCE – External Review
550 W. 7th Avenue, Suite 1560 Anchorage, Alaska 99501-3567
Tel: (907) 269-7900 Fax: (907) 269-7910 TTY/TDD: 711 or (800) 770-8973

General Information:

Name of Treating Health Care Provider:_____

Mailing Address: _____

_____

City: _____ State: _____ Zip: _____

Phone Number _____ Fax Number _____

Licensure and Area of Clinical Specialty:_____

Scientific Study References: _____

Certification:

I_____hereby certify I am the Treating Physician for _____ (Covered Person) and that, in my opinion, the experimental or investigational treatment described below (and/or attached) is likely to be more beneficial than other available standard health care services or treatments,

-and/or- that I am a Licensed Physician Board-Certified Physician Board-Eligible Physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, and that scientifically valid studies using accepted protocols, attached hereto, demonstrate that the experimental or investigational treatment described below (and/or attached) is likely to be more beneficial to the covered person than other standard health care services or treatments.

Experimental or Investigational Treatment Description:_____

_____

(Attach additional support and explanation if necessary)

Signature: _____ Date: _____