AULTCARE

TREATING PHYSICIAN CERTIFICATION FOR EXPERIMENTAL/INVESTIGATIONAL ADVERSE BENEFIT DETERMINATIONS

NOTE TO THE TREATING PHYSICIAN

Covered persons may request an external review when a health plan issuer has denied a healthcare service or course of treatment that is considered experimental or investigational and is NOT explicitly listed as an excluded benefit under the covered person's health benefit plan. This form is for the purpose of providing the certification necessary to obtain a review. Please complete the entire form including the certification and return the executed form via one of the methods below.

MAILING ADDRESS

Attention: Grievance and Appeal Coordinator
P.O. Box 6029
Canton, Ohio 44706

Fax Number: 330-363-3066

Email Address: Aappeals@aultcare.com

GENERAL INFORMATION			
Name of Covered Person/Patient		Covered Person's Health Plan ID Number	
Name of Treating Physician			
Licensure and Area of Clinical Specialty			
Mailing Address	City	State	Zip Code
Phone Number	Email Address	Fax Number	
Contact Person	Phone Number		

External Review Specifications

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); and that I have requested the authorization for a drug, device, procedure, or therapy denied for coverage due to the health plan issuer's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements.

Continued on next page.

In my medical opinion as the covered person's treating physician, I hereby certify to the following (select all that apply):

- ☐ **Standard healthcare services have not been effective in improving the condition of the covered person.**
- ☐ **Standard healthcare services are not medically appropriate for the covered person.**
- ☐ **There is no available standard healthcare service covered by the health plan issuer that is more beneficial than the requested healthcare service.**

Please provide a description of the recommended or requested healthcare service or treatment that is the subject of the adverse benefit determination. Include any documentation that will be beneficial to the review process. Attach additional sheets as necessary.

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Treating Physician Printed Name

_____ _____

Signature **Date**