**TREATING PROVIDER OPINION FOR INTERNAL APPEAL AND/OR EXTERNAL REVIEW (Kentucky)**

**Note to the Treating Provider**

Covered Persons may request an Internal Appeal and/or External Review when a health plan issuer has denied a health care service or course of treatment. The standard Internal Appeal process can take up to 30 days and External Review process can take up to 45 days from the request date to the date a decision is rendered. Expedited Appeals or Reviews are only available under the circumstances shown below. This form is for the purpose of providing the opinion necessary to obtain an Expedited Appeal or External review. Please complete the General Information section along with the appropriate opinion and return the executed form to CareSource at any of the addresses shown below:

Fax Number: **[Insert]**

Email Address: **[Insert]**

Mailing Address: **CareSource, Attn:** Member Appeals, P.O. Box 1947, Dayton, OH 45401-1947

**General Information**

Name of Covered Person/Patient:

Covered Person’s Health Plan ID Number:

Hospital (if hospitalized):

Name of Treating Physician:

Licensure and Area of Clinical Specialty:

Mailing Address: Phone Number:

Email Address: Fax Number:

Contact Person: Phone Number:

**Expedited Internal Appeal Opinion or Expedited External Review Opinion: Covered Person is Hospitalized**

I hereby certify that I am a treating provider for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereafter referred to as “the covered person”) and the covered person is currently hospitalized. For this reason, the covered person’s Internal Appeal or External Review should be processed on an expedited basis.

Treating Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Expedited Internal Appeal Opinion or Expedited External Review Opinion: Covered Person’s Health is at Risk**

I hereby certify that I am a treating provider for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereafter referred to as “the covered person”) and that adherence to the standard time frame for conducting a standard Internal Appeal (up to 30 days) or External Review (up to 45 days) could, in my professional judgment and opinion, in the absence of immediate medical attention, place the health of the covered person or her unborn child in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of a bodily organ or part. For this reason, the covered person’s Internal Appeal or External Review should be processed on an expedited basis.

Treating Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Concurrent Expedited Internal Appeal and Expedited External Review Opinion**

I hereby certify that I am a treating provider for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereafter referred to as “the covered person”) and (select all that apply):

❒ that adherence to the standard time frame for conducting an Expedited Internal Appeal of rending a decision within 3 business days from date of request could, in my professional judgment and opinion, in the absence of immediate medical attention, place the heath of the covered person or her unborn child in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of a bodily organ or part. For this reason, the covered person’s Expedited Internal Appeal should be conducted simultaneously with an Expedited External Review.

❒ that the recommended or requested experimental or investigational treatment would, in my professional judgment and opinion, be significantly less effective if not promptly initiated. For this reason, the covered person’s Expedited Internal Appeal should be conducted simultaneously with an Expedited External Review. (NOTE: You must also attach the completed Treating Provider Opinion Form for Experimental/ Investigational Adverse Benefit Determinations).

Treating Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

If you need help with this form, please call our Member Services department at 1-888-815-6446, Monday through Friday, 7:00 a.m. to 7:00 pm.

Enclosure: AM-EXCM-0255 – Notices Alternate Language Taglines

KY-EXCM-0028a