For Use with Expedited Review Only

To Be Completed by Physician

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The South Dakota Division of Insurance oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our division. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed within 72 hours. **This form is for the purpose of providing the certification necessary to trigger expedited review.**

General Information

Name of Treating Health Care Provider					
Address					
City		State		ZIP	
Phone		Fax			
E-mail					
Licensure/Area of Clinical Specialty					
Name of Patient					
Patient's Insurer Member ID#					

CERTIFICATION

I hereby certify that: I am a treating health care provider for _____ hereafter referred to as "the patient"; that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____

Treating Health Care Provider's Name (Please Print)

_____ _____

Signature Date