

OHIO DEPARTMENT OF INSURANCE
MODEL 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 health care 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 to ***[insert health plan issuer]*** at any address shown below.

Fax Number:

Email Address:

Mailing Address:

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:

Phone Number:

Email Address:

Fax Number:

Contact Person:

Phone Number:

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:

OHIO DEPARTMENT OF INSURANCE
MODEL TREATING PHYSICIAN CERTIFICATION FOR EXPERIMENTAL/INVESTIGATIONAL
ADVERSE BENEFIT DETERMINATIONS

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

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

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

Treating Physician Printed Name:

Signature

Date