Member Appeals and Grievance Packet

CAREFULLY READ THE INFORMATION IN THIS PACKET. KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL ADVERSE DETERMINATIONS MADE ABOUT YOUR HEALTHCARE.

An Independent Licensee of the Blue Cross Blue Shield Association

DISPUTES ELIGIBLE FOR ARIZONA'S HEALTHCARE APPEALS PROCESS

You can file an appeal when AZ Blue notifies you of an "Adverse Determination." This happens when we decide that a requested service or a claim for service or a denial, reduction, or termination of service, in whole or in part, is:

Not medically necessary or appropriate, including the healthcare setting, level of care, or effectiveness of a treatment or service.	Experimental or investigational.	Not a covered service.

An Adverse Determination also includes: (i) a cancellation of the policy back to the effective date due to a reason other than failure to pay premiums, also known as a "rescission of coverage" and (ii) when we decide that an out-of-network claim is not subject to protections from balance billing under the federal No Surprises Act, but you think it should be.

Some disputes can't be appealed. For example, you disagree with:

- The amount we paid for a service or treatment
- How we are coordinating benefits when you have coverage with more than one insurer
- The amount we applied for your deductible or out-of-pocket maximum
- The amount we calculated for your cost share obligation like copayments and coinsurance

If you disagree with these kinds of decisions, you can dispute them through other processes. Contact us to ask about filing a member grievance. Also see page 13 of this packet.

WHO CAN FILE A HEALTHCARE APPEAL OR GRIEVANCE?

You can file an appeal for yourself. The following authorized representatives can also file an appeal on your behalf and do not need any special authorization form:

- Your treating provider acting on your behalf
- A parent on behalf of a minor

If you are the member filing an appeal, you can work with your treating provider to help you with supporting information, such as medical records. In Arizona, most healthcare appeals are filed by treating providers acting on behalf of their patients.

The individuals listed below may appeal a decision for you, if you send AZ Blue the required proof of authority:

Third Party Representative	Proof of Authority
Member's Legal Guardian	Official copy of the court order appointing the guardian
Your Agent	Durable Power of Attorney that complies with A.R.S. § 14-5501 (or equivalent statute from other state) authorizing the agent to appeal or grieve a healthcare decision; or Health Care Power of Attorney that complies with A.R.S. § 36-3221 (or equivalent) and authorizes the agent to make healthcare treatment decisions for you
Your Surrogate	Someone who qualifies as a surrogate as defined by A.R.S. §36-3231 (or equivalent statute from another state) and Includes a written confirmation from a treating provider that the member is unable to make or communicate healthcare treatment decisions
Executor or Personal Representative	Official copies of the death certificate and court order appointing the executor or personal representative
Court Appointed Representative	Adult authorized by any other type of court order to make healthcare decisions for a member Official copy of the court order

If AZ Blue receives an appeal or grievance request from a third party (other than your treating provider) who claims to be your authorized representative, including the examples in the table above, AZ Blue may require you to confirm to us in writing the scope of the third party's authorization. We may not recognize the third party's authority until we receive your confirmation.

TOOLS FOR FILING A HEALTHCARE APPEAL

In this packet you will find forms you can use for your appeal. You are not required to use them and we cannot reject your appeal if you do not use them. To file an appeal, you can call us or send us a request in writing. If you need help in filing an appeal, or you have questions about the appeals process, call us at the phone number shown on the back of your ID card or listed on the CONTACT US page in this packet.

If you have general questions about healthcare appeals, please contact the Arizona Department of Insurance and Financial Institutions (AZ DIFI) Consumer Services Section at **602-364-2499** or visit the AZ DIFI website at **difi.az.gov.**

DESCRIPTION OF THE APPEALS PROCESS

There are two types of appeal time frames:

- a standard appeal
- an expedited appeal for urgent matters

The expedited appeals process operates in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Appeals are categorized as either Medical Necessity or Coverage. The designation will affect how the case is handled by AZ Blue and by the AZ DIFI. It also will affect the rights you have once the healthcare appeals process has been completed.

STANDARD VS EXPEDITED TIME FRAMES: IS IT URGENT

If your appeal is urgent, your treating provider must certify and provide supporting documentation to us that the time frame for a standard appeal (15 days for a service not yet provided) would cause a significant negative change in your condition. At the end of this packet is a form that a treating provider can use to make the required certification. Instead of this form, your treating provider could also send a written request or create a form with similar information. Your treating provider must send the certification and any supporting documentation to us using the information on the CONTACT US page in this packet.

Expedited appeals can only be used for services that haven't yet received. Here are some examples, but this isn't a complete list:

- You are in a course of treatment and we have said we won't approve continuation of the treatment
- We denied prior authorization for a service that you need avoid permanent harm, severe pain, or significant deterioration in your condition.

GENERAL APPEALS PROCESS INFORMATION

- You have **two years** from the date of an Adverse Determination to begin the healthcare appeals process.
- You must send requests for all healthcare appeal levels directly to AZ Blue using the information on the CONTACT US page in this packet.
- Your appeal must go through a First Level Internal Appeal and then to an External Review. The First Level Internal Appeal must be completed or waived, before you can seek an External Review. You may simultaneously initiate an Expedited External Review and a First Level Internal Appeal for services that you have not yet received.
- The First Level Internal Appeal and the Expedited First Level Internal Appeal are completed by AZ Blue. We send the External Review and Expedited External Reviews to the AZ DIFI.
- At any time, AZ Blue may waive the internal level of review and move an appeal to the External Review level.
- Before AZ Blue makes a Final Internal Adverse Determination that relies on new or additional information received by AZ Blue, we will provide you with a copy of the new or additional information, free of charge, to allow you an opportunity to respond.
- To qualify for the healthcare appeals process, there is no minimum dollar amount for the value of a claim or service.
- There is no fee to you or your provider for any level of appeal.
- It is important to pay attention to deadlines at each level of review.
- Your plan has **two standard appeal levels:**

  1. First Level Internal Appeal
  2. External Review

- You also have **two expedited appeal levels** for services that you have not yet received, when your provider certifies that your condition qualifies as urgent because waiting for the standard appeal time period of 15 days could:

  1. Jeopardize your life, health, or ability to regain maximum function
  2. Cause a significant negative change in your medical condition
  3. Subject you to severe pain that cannot be managed without the requested service. The two expedited appeal levels are:

  1. Expedited First Level Internal Appeal
  2. Expedited External Review

- If the External Review involves medical necessity, the AZ DIFI selects an Independent Review Organization (IRO) that is completely independent of AZ Blue to make the determination. The IRO reviewer will be a provider that typically manages the condition that is the subject of the appeal.
- If the appeal involves whether a treatment or service is covered in your policy, the AZ DIFI is the external reviewer.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

• First Level Internal Appeal

You can request a First Level Internal Appeal of an Adverse Determination **if all of the following apply:**

- You request an appeal within **two years** after the date we make the Adverse Determination.
- You have coverage with us.
- We denied your request for a covered service or claim.
- You do not qualify to have your appeal expedited.
- You send your request to us using the information in the CONTACT US page in this packet.

At any time, AZ Blue may decide to waive the internal review and send your appeal to the AZ DIFI for External Review.

Determination and Time Frames:

AZ Blue has:

- **15 days** to decide for a service not yet provided
- **30 days** to decide for a service already provided

You have **four months** to appeal to the External Review level or to request an External Review.

If we overturn our original denial, we will authorize the service or pay the claim and the appeal is over.

If we uphold the denial, our decision letter will explain the reasons why and the information on which we based our decision. Our decision letter will also include instructions for the next steps in the appeal process.

EXTERNAL REVIEW

You may appeal to the External Review level only after you have completed the internal level of appeal, unless the internal level of appeal was waived. You have four months after you receive a Final Internal Adverse Determination to send us your written appeal request and any additional supporting information for External Review. Send your request to us using the information on the CONTACT US page in this packet.

This level of review also applies if we elect to waive the internal level of review.

There are **two types of External Review,** depending on the issues in your case:

1. Medical Necessity
2. Contract Coverage

1. Medical Necessity

These are cases where we have decided not to authorize a service because we determined that the service you or your treating provider are asking for is not medically necessary to treat your health condition. For medical necessity cases, the independent reviewer is a provider retained by an IRO, which is procured by the AZ DIFI and not connected with AZ Blue. The IRO reviewer must be a provider who typically manages the health condition under review. Medical necessity appeals are subject to the following time frames:

- Within **five business days** of receiving your request, AZ Blue will:
  1. Mail a written acknowledgment of your request to the AZ DIFI, you, and your treating provider. This acknowledgment will include notice that you have **five business days** after receiving the notice to submit any additional written evidence to the AZ DIFI for consideration by the external reviewer. The AZ DIFI will forward it to the IRO. If you provide additional information after **five business days** the IRO may or may not consider it.
  2. Send the AZ DIFI all of the following:
     a. The request for review
     b. Your policy, evidence of coverage, or similar document
     c. All medical records and supporting documentation AZ Blue used to render its determination(s)
     d. A summary of the applicable issues including a statement of the determination
     e. The criteria used and clinical reasons for the determination
     f. The relevant portions of our utilization review guidelines
     g. The name and credentials of the healthcare provider who reviewed and upheld the determination(s) at the first level internal appeal
- Within **five days** of receiving the appeal the AZ DIFI will send all the submitted information to an IRO.
- Within **21 days** of receiving the appeal the IRO will make a written determination and send the determination to the AZ DIFI.
- Within **five business days** of receiving the IRO's determination the AZ DIFI will send a written notice of the determination to you, your treating provider, and AZ Blue.

The Determination

- If the IRO decides that we should provide the service or pay the claim, we will authorize the service or pay the claim.
- If the IRO agrees with our decision to deny the service or payment, the appeal is over and your only further option is to pursue a claim in Superior Court.

2. Contract Coverage

These are cases where we have denied coverage because we determined that the requested service is not covered under your insurance policy. For contract coverage cases, the AZ DIFI is the independent reviewer. Contract coverage appeals are subject to the following time frames:

- Within **five business days** of receiving your request, AZ Blue will:
  1. Send a written acknowledgment of your request to the AZ DIFI, you, and your treating provider.
  2. Send the AZ DIFI all of the following:
     a. The request for review
     b. Your policy, evidence of coverage or similar document
     c. All medical records and supporting documentation AZ Blue used to render its determination(s)
     d. A summary of the applicable issues including a statement of our determination
     e. The criteria used and clinical reasons for the determination
     f. The relevant portions of AZ Blue's utilization review guidelines
     g. The name and credentials of the healthcare provider who reviewed and upheld the determination(s) at the First Level Internal Appeal
- Within **15 business days** of receiving this information the AZ DIFI will determine whether the service or claim is covered and send a written notice of their determination to you, your treating provider, and us.

Referral to an IRO for Contract Coverage Appeals:

- If AZ DIFI is unable to determine issues of coverage, they will forward the case to an IRO.
- The IRO will have **21 days** to make a determination and send it to the AZ DIFI.
- The AZ DIFI will have **five business days** after receiving the IRO's determination to send the notice of determination to you, your treating provider, and us.

The Determination

- If the AZ DIFI decides that we should provide the service or pay the claim, we will do so.
- If either you or we disagree with the AZ DIFI's determination on a coverage issue, you or we may request a hearing with the Arizona Office of Administrative Hearings (AZ OAH) by sending a request to the AZ DIFI within **30 days** after receiving the AZ DIFI's determination.

INFORMATION ABOUT INDEPENDENT REVIEW ORGANIZATIONS (IROs)

- The AZ DIFI contracts directly with multiple IROs. They each maintain large rosters of many types of specialties of physicians and other licensed healthcare professionals.
- There is no cost to a member or provider for any part of the appeal process. If the services of an IRO are used, the AZ DIFI selects and pays the IRO, then bills the insurer for reimbursement after the appeal is completed.
- The IRO will check that their reviewer does not have a conflict of interest with the insurer, member, or treating provider, and was not involved in the original denial determination or any previous appeal for the same member.
- There will be no communication with the IRO by you or us. The IRO will complete their review using the documentation in your appeal.
- The IRO reviewer will be a provider who typically manages the condition under review.
- The IRO's determination is binding on all parties. Any further challenges must proceed through Superior Court.
- The IRO, the AZ DIFI, or the AZ OAH cannot order an insurer to provide or pay for a treatment or service that is excluded under your insurance policy, even if determined to be medically necessary.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited First Level Internal Appeal

You may obtain an Expedited First Level Internal Appeal of an Adverse Determination for a service you haven't yet received if your treating provider certifies in writing and provides supporting documentation that the time for a standard appeal is likely to cause a significant negative change in your medical condition.

At the end of this packet is a form that your treating provider may use for the certification, but that form is **not required.** Your provider could also provide a written request or create a form with similar information. Your treating provider must send the certification and documentation to us using the information on the CONTACT US page in this packet.

AZ Blue has **72 hours** after we receive the request to decide whether we should change our determination and authorize your requested service. Within this time frame, we will call and tell you and your treating provider about our decision. We will also send you a written determination.

If we overturn our determination, we will authorize the service and the appeal is over.

If we uphold the denial, our decision letter will explain the reasons why and the information on which we based our decision. Our decision letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited First Internal Level Appeal and Expedited Appeal levels and send your appeal to the AZ DIFI for Expedited External Review.

Expedited External Review

Unless we waive the Expedited First Level Internal Appeal of review and send your appeal to the AZ DIFI for Expedited External Review, **you may request an Expedited External Review** after you have completed an Expedited First Level Internal Appeal or simultaneously at any internal level of review.

You have **four months** after you receive a Final Internal Adverse Determination to send to us your **written** request for Expedited External Review. If the treatment or service is considered experimental or investigational, you can make an oral request if your treating physician certifies in writing that the requested service or treatment would be significantly less effective if not promptly initiated. Send us your request and any additional supporting information using the information on the CONTACT US page in this packet.

There are **two types of Expedited External Review** depending on the issue in your case:

1. Medical Necessity
2. Contract Coverage

1. Medical Necessity

These are cases where we have decided not to authorize a service because we determined that the service you or your treating provider are asking for is not medically necessary to treat your condition.

For medical necessity cases, the independent reviewer is a provider retained by an IRO, which is procured by the AZ DIFI and not connected with AZ Blue. The IRO reviewer must be a provider who typically manages the condition under review. Medical necessity appeals are subject to the following time frames:

- Within **one business day** of receiving your request, AZ Blue will
    1. Send a written acknowledgment of the appeal request to the AZ DIFI, you, and your treating provider.
    2. Send the AZ DIFI all of the following:
        a. The request for review
        b. Your policy, evidence of coverage, or similar document
        c. All medical records and supporting documentation used to render our determination
        d. A summary of the applicable issues, including a statement of our determination
        e. The criteria used and clinical reasons for our determination
        f. The relevant portions of our utilization review guidelines
        g. The name and credentials of the healthcare provider who reviewed and upheld the denial at the internal levels of review
- Within **two business days** of receiving the appeal, the AZ DIFI will send all the submitted information to the IRO.
- Within **72 hours** of receiving the appeal, the IRO will make a determination and send their determination to the AZ DIFI.
- Within **one business day** of receiving the IRO's determination, the AZ DIFI will send a notice of the determination to you, your treating provider, and us.

The Determination

- If the IRO decides that we should provide the service we will authorize the service.
- If the IRO agrees with our determination to deny the service the appeal is over and your only further option is to pursue a claim in Superior Court.

2. Contract Coverage

These are cases where we have denied coverage because we determined that the requested service is not covered under your insurance policy. For contract coverage cases the AZ DIFI is the independent reviewer.

Contract Coverage appeals are subject to the following time frames:

- Within **one business day** of receiving your request, we will:
  1. Send a written acknowledgment of the request to the AZ DIFI, you, and your treating provider.
  2. Send the AZ DIFI all of the following
     a. The request for review
     b. Your policy, evidence of coverage, or similar document
     c. All medical records and supporting documentation used to render our determination
     d. A summary of the applicable issues, including a statement of our determination
     e. The criteria used and any clinical reasons for our determination
     f. The relevant portions of our utilization review guidelines
- Within **two business days** of receiving this information the AZ DIFI will determine whether the service or claim is covered under your insurance policy and send a written notice of their determination to you, your treating provider, and us.

Referral to an IRO for Contract Coverage Appeals:

The AZ DIFI may be unable to determine issues of coverage. If this occurs:

- The AZ DIFI will forward the case to an IRO. The IRO will have **72 hours** to make a determination and send it to the AZ DIFI.
- The AZ DIFI will have **one business day** after receiving the IRO's determination to send the notice of determination to you, your treating provider, and us.

The Determination

- If the AZ DIFI decides that we should provide the service or pay the claim, we will do so.
- If either you or we disagree with the AZ DIFI's determination on a coverage issue, you or we may request a hearing with the Arizona Office of Administrative Hearings (AZ OAH) by sending a request to the AZ DIFI within **30 days** after receiving the AZ DIFI's determination.
- You may have other legal recourse to challenge AZ Blue's decision in court.

THE ROLE OF THE ARIZONA DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS (AZ DIFI)

Arizona law requires "any member who files a complaint with the [AZ DIFI] relating to an Adverse Determination to pursue the review process prescribed" by law (A.R.S. § 20-2533(F)). This means that you must pursue the healthcare appeals process for all appealable adverse determinations before the AZ DIFI can investigate a complaint you may have against AZ Blue based on the determination at issue in the appeal.

The appeal process requires the AZ DIFI to:

1. Oversee the appeals process
2. Maintain copies of each utilization review plan submitted by insurers
3. Receive, process, and act on requests from an insurer for External Review
4. Enforce the determinations of insurers
5. Review determinations of insurers
6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the AZ OAH
7. Issue a final administrative determination on coverage issues, including the notice of the right to request a hearing at AZ OAH

DOCUMENTATION FOR AN APPEAL

- If you file an appeal, you must include any material justification or documentation.
- If you gather new information during the course of your appeal you should give it to us as soon as you get it.
- You must also give us the address and phone number or email where you can be contacted.
- If your appeal goes to external review, the AZ DIFI may contact you by email from a generic email address **(hca@difi.az.gov).**
- If the appeal is already at the External Review level, you will be notified in writing that you have **five business days** to send any additional information to the AZ DIFI.
- If you submit anything after the **five business days,** it does not have to be considered in your appeal.

RECEIPT OF DOCUMENTS

Any written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing. "Properly addressed" means your last known mailing address. Any document may alternatively be sent electronically where a member has elected electronic delivery.

OBTAINING MEDICAL RECORDS

Arizona law (A.R.S. § 12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The healthcare provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated healthcare decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your healthcare decision-maker or a person designated in writing by your healthcare decision-maker unless you limit access to your medical records only to yourself or your healthcare decision-maker.

Confidentiality: Medical records disclosed under A.R.S. § 12-2293 remain confidential. If you participate in the appeal process the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

If you reside outside the state of Arizona, the laws that govern medical records and providers in your state may vary.

MEMBER GRIEVANCE PROCESS FOR DISPUTES ABOUT MEMBERS COST SHARE AND PLAN ALLOWED AMOUNT

• First Level Member Grievance

You can request a First Level Member Grievance if you disagree with the member cost share or the plan allowed amount, if all of the following apply:

- You request a grievance within one year after the date we make the decision you want to grieve.
- You have coverage with us.
- You send your request to us using the information on the CONTACT US page in this packet.

Determination and Time Frames:

- AZ Blue has **30 days** to make a decision.
- AZ Blue will send you and your treating provider a written decision letter.

If we overturn our determination, we will reprocess the claim and the grievance is over.

If we uphold the current processing of the claim, our decision letter will explain the reasons why and the information on which we based our decision. This will be the end of the grievance process, no further review is available.

You may have other legal recourse to challenge AZ Blue’s decision in court.

CONTACT US

Contact us if you have questions with how we processed your claim.

Call AZ Blue Customer Service Monday through Friday, 8 a.m. to 4:30 p.m. MST (except holidays) using the phone number on the back of your member ID card or at **602-864-4400** or **1-800-232-2345.**

For an appeal or member grievance call, fax, or write to:	Chiropractor Services
AZ Blue Attn: Medical Appeals & Grievances Coordinator P.O. Box 13466–Mail stop A116 Phoenix, AZ 85002-3466 Phone: 602-864-4400 or 1-800-232-2345 Fax: 602-544-5601 Email: appeals@azblue.com	American Specialty Health Networks, Inc. Attn: Appeals Coordinator P.O. Box 509140 San Diego, CA 92150 Phone: 1-800-972-4226 Fax: 1-877-404-2746

Appeal Resources

AZ Blue customer service representatives can answer questions about the appeal process and help you with filing an appeal. The AZ Blue customer service number is **602-864-4400** or **1-800-232-2345** (toll free).

If you have general questions about healthcare appeals, you can contact the Arizona Department of Insurance and Financial Institutions (AZ DIFI) Consumer Services Section at **602-364-2499** or visit the AZ DIFI website at **difi.az.gov.**

If you are enrolled in a group health plan through your work, you can also contact the U.S. Department of Labor—Employee Benefits Security Administration at **1-866-444-EBSA (3272).**

If you are hearing impaired (TTY), please call **602-864-4823** or **1-800-232-2345, ext. 4823.**

Appeal/Grievance Request Form

You may use this form to tell AZ Blue you want to appeal or grieve a decision.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Member Name ______________________________

Member ID # ____________________ Group # ____________________

Name of representative pursuing appeal, if different than above ____________________

Phone # ______________________________

Mailing Address ______________________________

City ____________________ State ________ ZIP Code ____________________

Type of Appeal/Grievance ☐ Denied Claim ☐ Denied Service Not Yet Receive ☐ Cost Share Dispute

Claim # (if applicable) ____________________ Date of Service ______ / ______ / ______

If you are appealing AZ Blue's decision to deny a service you have not yet received, could a 15 to 30 day delay in receiving the service likely seriously jeopardize your life or health or your ability to regain maximum function, cause a significant negative change in your medical condition, or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider can send us the attached certification and documentation supporting the need for an expedited appeal.

What action or decision are you disputing? ______________________________

Explain why you believe the decision or action was wrong and what you would like AZ Blue to do differently:

____

____

____

(Attach additional sheets of paper, if needed)

If you have questions about the appeal or grievances process or need help to prepare your request, please call AZ Blue at **602-864-4400** or **1-800-232-2345.**

Make sure that everything that shows why you believe AZ Blue should process your claim differently or authorize a service, including: ☐ Medical Records ☐ Supporting Documentation (letter from your doctor, brochures, notes, receipts, etc.) You may attach the certification from your treating provider if you are seeing an expedited review. Send to:

Blue Cross Blue Shield of Arizona
Attn: Medical Appeals and Grievances Coordinator
P.O. Box 13466, Mail stop A116
Phoenix, AZ 85002-3466
Phone: 602-544-4938 or 1-866-595-5998
Fax: 602-544-5601

Signature of member or authorized representative ____________________ Date___/____/______

Provider Certification Form for Expedited Appeal

Is the appeal for a service that the patient has not yet received? ☐ ***Yes*** ☐ ***No***
If "Yes," continue with this form.
If "No," the patient must pursue the standard appeal process and cannot use the expedited appeals process.

Provider Information		
Treating Physician/Provider		
Phone #	Fax #	
Address		
City	State	ZIP Code

Patient Information		
Member Name		
Member ID #	Group #	
Phone #	Fax #	
Address		
City	State	ZIP Code

What service denial is the patient appealing? ______________________________

____

____

Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient: ______________________________

____

____

Fax this form with any supporting documentation and medical records to:
AZ Blue at **602-544-5601**

I certify, as the patient's treating provider, that delaying the patient's requested service for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health, or ability to regain maximum function, cause a significant negative change in their medical condition, or subject the patient to severe pain that cannot be adequately managed without the requested service.

Provider's Signature: ______________________________ Date _____/____/_______

Printed Name: ______________________________

If you have questions about the appeals process or need help to prepare your appeal, please call AZ Blue at **602-864-4400** or **1-800-232-2345.**

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-446-8331 (TTY: 711).

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-446-8331 (TTY: 711).

Navajo: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-800-446-8331 (TTY: 711).

Chinese Simplified: 如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-446-8331（文本电话：711）。

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-446-8331（TTY：711）。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-446-8331 (TTY: 711).

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-446-8331 (TTY: 711).

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-446-8331 (Người khuyết tật: 711).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-446-8331 (TTY: 711).

Korean: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-446-8331 (TTY: 711).

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-446-8331 (TTY: 711).

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (TTY: 711) 1-800-446-8331.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-446-8331 (TTY: 711) ।

Farsi (Persian)

توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-800-446-8331 (تله‌تایپ: TTY: 711)

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-446-8331 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ”

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-446-8331（TTY：711）。

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