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 #	
Phone #	Fax #	
Address		
City	State	ZIP Code

What service denial is the patient appealing? ____

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

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Fax this form with any supporting documentation and medical records to:
BCBSAZ 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 BCBSAZ at 602 864-4400 or 800 232-2345.