Provider Certification Form for Expedited Appeal

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

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? _____

_____

_____

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:
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: _____
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