Superior Vision
Complaints and Appeals
PO Box 547
Troy, NY 12181

PROVIDER CERTIFICATION FORM
FOR EXPEDITED MEDICAL REVIEWS AND EXPEDITED APPEALS

(This form cannot be used if the service has already been provided.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 30 days) "is likely to cause a significant negative change in the [patient's] medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider _____
Phone _____ FAX _____
Email _____
Mailing Address _____
City _____ State _____ Zip Code _____

PATIENT INFORMATION

Patient's Name _____ Member ID _____
Email _____ Phone _____
Mailing Address _____
City _____ State _____ Zip Code _____

INSURER INFORMATION

Insurer Name _____
Phone _____ FAX _____
Email _____
Mailing Address _____
City _____ State _____ Zip Code _____

- Is the appeal for a service that the patient has already received? ☐ Yes ☐ No
  If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process.
  If "No," continue with this form.
- What adverse determination is being appealed? _____

_____

_____

- Explain why you believe the patient needs the requested treatment or service and why the time for the standard appeal process will cause a significant negative change in the patient's medical condition that is the subject of the appeal.

_____

_____

_____

Attach additional sheets, if needed, and include: ☐ Medical records ☐ Supporting documentation

If you have questions about the appeals process or need help preparing this certification, you may call the Arizona Department of Insurance and Financial Institutions Consumer Services number (602) 364-2499 or Superior Vision Provider Customer Service at 877-235-5317.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the standard appeal process is likely to cause a significant negative change in the patient's medical condition at issue.

_____ _____
Signature of Treating Physician/Provider Date