STATE OF ALASKA
DIVISION OF INSURANCE
550 West 7th Avenue, Suite 1560 Anchorage, AK 99501-3567
Telephone: (907) 269-7900 Fax: (907) 269-7910 TTY/TDD: 711 or (800) 770-8973

CERTIFICATION OF TREATING HEALTHCARE PROVIDER

Complete if required by the External Healthcare Review Application

This form provides medical certification for the following review types:

- Expedited External Healthcare Review
- Experimental / Investigational External Healthcare Review
- Expedited Experimental / Investigation External Healthcare Review

Please check the appropriate boxes for certification.
***IF CERTIFYING THE EXTERNAL REVIEW FOR EXPEDITED EXPERIMENTAL / INVESTIGATIONAL SERVICES, PLEASE COMPLETE BOTH "A" & "B" CERTIFICATIONS BELOW.**

☐ A. Expedited

Expedited external review is available in cases where denial of the healthcare service or course of treatment would seriously jeopardize the life or health of the covered person / patient or would jeopardize the covered person / patient's ability to regain maximum function.

Certification for Expedited Review

I, _____, hereby certify I am the treating physician for covered person / patient _____, and that in my opinion, the denial of the healthcare service or course of treatment described below (and/or attached) would seriously jeopardize the life or health of my covered person / patient, or jeopardize their ability to regain maximum function of _____ _____.

Signature: _____ Date: _____

☐ B. Experimental / Investigational

A covered person / patient may request an external review when a health insurance company has denied coverage for a prospective healthcare service or course of treatment on the basis of a utilization review determination that the requested healthcare service or course of treatment is investigational or experimental.

Certification for Experimental / Investigational Treatment

I, _____, hereby certify I am the treating physician for covered person / patient _____, and that, in my opinion, the experimental / investigational treatment described below (and/or attached) is likely to be more beneficial than other available standard healthcare services of treatments.

Signature: _____ Date: _____

Treatment Description

(Please include additional pages if necessary. Sign and date each page.)

Treating Provider Information

Name of Treating Healthcare Provider: _____

Clinic / Hospital: _____

Licensure and Area of Clinical Specialty: _____

Treating Provider's Contact Person: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Daytime Phone: _____ Fax Number: _____

Applications for **Expedited** External Review may be faxed
Attn: Consumer Services to **(907) 269-7910**
or sent by overnight carrier to:
Alaska Division of Insurance
Attn: Consumer Services
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501-3567

If you have questions pertaining to this form or the External Healthcare Review process or related application, please review the Consumer Guide to External Healthcare Review on our website or contact Consumer Services at the Alaska Division of Insurance at (907) 269-7900.