THE OHIO STATE UNIVERSITY
HEALTH PLAN

The Ohio State University
Health Plan Inc.

700 Ackerman Road
Suite 1007
Columbus, OH 43202

614-292-4700 Phone
800-678-6269 Phone
614-292-2667 Fax

www.osuhealthplan.com

TREATING PHYSICIAN CERTIFICATION FOR INTERNAL APPEAL AND/OR EXTERNAL REVIEW

Note to the Treating Physician

Covered Persons may request an internal appeal and/or external review when a health plan issuer has denied a health care service or course of treatment. Standard internal appeals can take up to 10 days and external review processes can take up to 30 days from the request date to the date a decision is rendered. Expedited appeals or reviews are only available under the circumstances shown below. This form is for the purpose of providing the certification necessary to obtain an expedited appeal or review. Please complete the General Information section along with the appropriate certification and return the executed form to OSU Health Plan at any of the addresses shown below:

Fax Number: 614-292-2667
Email Address: UtilizationManagement.OSUHealthPlan@OSUMC.edu
Mailing Address: 700 Ackerman Road, Suite 1007
Columbus, OH 43202

General Information	
Name of Covered Person/Patient	
Covered Person's Health Plan ID	
Reference Number (From Adverse Benefit Determination)	
Name of Treating Physician	
Licensure and Area of Clinical Specialty	
Mailing Address	
Contact Person	
Email Address	
Phone Number	
Fax Number	

Complete ONE of the following certifications:

1. Expedited **Internal** Appeal Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard internal appeal would, in my professional judgment, subject the covered person to severe pain that cannot be adequately managed without the requested care or treatment; and that, for this reason, the covered person's appeal should be processed on an expedited basis.

Treating Physician Printed Name:

_____

Signature Date

2. Internal Appeal Waiver Request and Expedited External Review Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); and (select all that apply):

- ☐ that adherence to the time frame for conducting an expedited internal appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's internal appeal requirement should be waived in order to conduct an expedited external review.
- ☐ that the recommended experimental or investigational treatment would, in my professional judgment, be significantly less effective if not promptly initiated; and that, for this reason, the covered person's expedited internal appeal requirement should be waived in order to conduct an expedited external review. I have attached the completed Treating Physician Certification Form for Experimental/ Investigational Adverse Benefit Determinations.

Treating Physician Printed Name:

_____

Signature Date

3. Expedited **External** Review Certification

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard external review would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's external review should be processed on an expedited basis.

Treating Physician Printed Name:

_____

Signature Date