NEW YORK STATE DEPARTMENT of FINANCIAL SERVICES

DFS Case #: _____

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL: RARE DISEASE DENIAL

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately. The attestation and supporting documents may be submitted via our secure portal. Or by mail to New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany NY 12210 or Fax: (800) 332-2729, or email earesponse@dfs.ny.gov. Please call 800-400-8882 if you need assistance.

If the patient has **not yet received the treatment,** and **the 30-day timeframe will seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health,** the patient's physician may request the appeal be expedited. The external appeal agent must make an expedited decision within 72 hours, instead of 30 days, whether you provide all necessary medical information or records to the agent or not. **You must send information to the agent immediately in order for it to be considered.**

Type of Review	☐ Standard Appeal (30 days)	☐ Expedited Appeal (72 hours)
If Expedited, check one:	☐ Expedited Appeal: Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized. ☐ Expedited Appeal: 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health.	
If Expedited:	☐ I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.	
	During non-business days, I can be reached at: ( )	

1. Name of Physician completing this form:			
To appeal a rare disease denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient, and may not be the patient's treating physician.			
2. Physician Street Address:			
Physician City, State, Zip:			
3. Contact Person:			
4. Contact Phone Number:	( )	Fax #:	( )
5. Contact Email (if e-mail is preferred):			
6. Name of Patient:			
7. Patient Street Address:			
Patient City, State, Zip:			
8. Patient Phone Number:	( )		
9. Patient Health Plan Name and ID Number:			

10. Rare Disease Denial - Physician Attestation: If provision of the service requires approval of an Institutional Review Board, include or attach the approval	
☐	As a physician, other than the patient's treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service.
☐ I do ☐ I do not have a material financial or professional relationship with the provider of the service (check one).	
Check one:	☐ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.
	☐ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

11. Physician Signature			
I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.			
Physician's Signature		Date:	
Physician Name: (Print Clearly):			