New York State of Opportunity. Department of Financial Services

DFS Case #: ______________________

PHYSICIAN ATTESTATION FOR AN EXPEDITED EXTERNAL APPEAL: FORMULARY EXCEPTION DENIAL

The patient's physician or prescriber must complete this attestation for any expedited formulary exception appeal. 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.

The external appeal agent must make an expedited decision within 24 hours, instead of 72 hours, 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.**

***** If expedited you must call 888-990-3991 immediately after you submit the appeal**.***

☐ I am requesting an expedited appeal for a Formulary Exception denial (24 hours)

☐ The patient is suffering from a health condition and has not yet received the treatment, or is undergoing a current course of treatment using a non-formulary drug. The 72-hour 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.

☐ 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 24 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: (   )

Physician/Prescriber completing this form:			
Physician/Prescriber Street Address:			
Physician/Prescriber City, State, Zip:			
Contact Person:			
Contact Phone Number:	( )	Fax #:	( )
Contact Email:			
Name of Patient:			
Patient Street Address:			
Patient City, State, Zip:			
Patient Phone Number:			
Patient Health Plan Name and ID Number:			

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 or Prescriber Signature:		Date:	
Physician or Prescriber Name: (print clearly)			