NEW YORK STATE OF OPPORTUNITY. | Department of Financial Services

DFS Case #: ______________________

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL: OUT OF NETWORK REFERRAL 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.**

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

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 out-of-network service denial (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), 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.			
2. Physician Street Address:			
Physician City, State, Zip:			
3. Contact Person:			
4. Contact Phone Number:	( )	Fax Number:	( )
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:			

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10. Out-of-Network Referral Denial - Physician Attestation:	
As the patient's attending physician, I certify that the in-network health care provider(s) recommended by the health plan do not have the appropriate training and experience to meet the particular health care needs of the patient. I recommend the out-of-network provider indicated below, who has the appropriate training and experience to meet the particular health care needs of the patient and is able to provide the requested health service.	
Name of out-of-network provider:	
Address of out-of-network provider:	
Training and experience of out-of-network provider: (e.g. board certification, years treating the condition, # of procedures performed and outcome, any other pertinent information).	

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):			