Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Expedited Appeal Request Form

This Expedited Appeal Request Form must be signed and attested to by the ordering physician or a standard appeal will be performed.

Expedited Appeal Request Form

APPLICANT NAME _____
[ ] Covered person [ ] Patient Provider [ ] Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____
Patient Name: _____
Address:_____
_____
_____
_____
Covered Person Phone #: Home (____)_____
Work (____)_____

INSURANCE INFORMATION

Insurer/HMO
Name:_____

Covered Person Insurance
ID#:_____

Insurance Claim/Reference #:

_____
Insurer/HMO Mailing Address:

_____
_____
_____
Insurer Telephone #:

_____

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider:

_____
Address:

_____
_____
_____
_____
Contact Person: _____
Phone: ( )_____
Medical Record #:_____

SUMMARY OF Expedited Appeal Review Request (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier and provide documentation that supports that the time for a standard review would seriously jeopardize the member's life or health or his/her ability to regain function)

_____
_____
_____
_____
_____

My signature attests to the position that the time for a standard review (15 days in this case) would seriously jeopardize the member's health, life or his/her ability to regain function.

_____ Date_____

Ordering Physician Signature