CERTIFICATION FOR EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

I hereby certify that I am a treating health care provider for _____ _____ (Covered Person) and that I have recommended the drug, device, procedure, or therapy that has been denied for coverage based on a determination that it is experimental or investigational. I understand that for the Covered Person to obtain the right to an external review of this adverse benefit determination, as a treating health care provider I must certify that the Covered Person's medical condition meets certain requirements.

In my professional opinion as the Covered Person's treating health care provider, I hereby certify to the following:

(Please check all that apply)

☐ 1. The Covered Person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

2. The Covered Person has a condition that qualifies under one or more of the following: (Please indicate which description(s) are applicable)

☐ Standard health care services or treatments have not been effective in improving the Covered Person's condition.

☐ Standard health care services or treatments are not medically appropriate for the Covered Person.

☐ There is no available standard health care service or treatment covered by the Covered Person's health plan that is more beneficial than the recommended health care service or treatment.

☐ The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explain: _____

_____

_____

_____

☐ 3. It is my professional opinion based on scientifically valid studies using accepted protocols that the health care service or treatment recommended is likely to be more beneficial to the Covered Person than any available standard health care services or treatments.

Explain: _____

_____

_____

_____

Please provide a description of the recommended health care treatment or service.

_____

_____

_____

_____

_____ _____

Treating Health Care Provider's Signature Date

_____

Printed Name