NEW YORK STATE DEPARTMENT of FINANCIAL SERVICES

DFS Case #: _____

PHYSICIAN ATTESTATION FOR AN EXPEDITED EXTERNAL APPEAL: MEDICAL NECESSITY DENIAL

The patient's physician must complete this attestation for any expedited external appeal of a health plan's denial of service. 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 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.**

☐ I am requesting an expedited appeal for a Medical Necessity denial (72 hours)

Please select one of these reasons for an 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.

☐ 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.

☐ 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: ( )

Name of Physician completing this form:			
Physician Street Address:			
Physician 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 Signature:		Date:	
Physician Name: (Print Clearly):			