State Corporation Commission
Bureau of Insurance – External Review
P.O. Box 1157
Richmond, VA 23218
Phone: 1-877-310-6560 Fax: (804) 371-9915
Email: externalreview@scc.virginia.gov

PHYSICIAN CERTIFICATION
EXPERIMENTAL or INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for_____(patient's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health carrier's determination that the proposed therapy is experimental or investigational. I understand that in order for the patient to obtain the right to an external review of this denial, as treating physician I must certify that the patient's medical condition meets certain requirements:

In my medical opinion as the Patient's treating physician, I hereby certify to the following:
(Please check all that apply. NOTE: Requirements 1 - 3 are necessary to qualify for external review; requirements 1 – 4 are necessary to qualify for expedited external review.**)**

☐ 1. I am a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the patient's condition.

2. The patient has a condition that qualifies under one or more of the following:
(Please indicate which description(s) apply):
   - ☐ Standard health care services or treatments have not been effective in improving the patient's condition;
   - ☐ Standard health care services or treatments are not medically appropriate for the patient; or
   - ☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

3.
   - ☐ The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the patient than any available standard health care services or treatments; **OR**
   - ☐ It is my medical opinion which is based on scientifically valid studies using accepted protocols, that the health care service or treatment requested by the patient and which has been denied is likely to be more beneficial to the patient than any available standard health care services or treatments.

☐ 4. The health care service or treatment recommended would be significantly less effective if not promptly initiated (required for expedited external review only).

Please provide a description below of the recommended or requested health care service or treatment that is the subject of the denial. (Please attach additional sheets as necessary.)

Treating Physician's Name (please print): _____

_____ _____
Physician's Signature Date

Description of the health care service or treatment that is the subject of the denial:

Physician's signature

Date