**Physician Certification for Internal Expedited Review**

**This form is to be completed by the treating physician when the covered person has a condition where the timeframe to complete a standard Internal Appeal with Jefferson Health Plans (30 days) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.**

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| **Patient Information** |
| **Last Name**  | **First Name** | **MI** |
| **Address** |
| **City** | **State** | **Zip** |

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| **Health Care Provider Information** |
| **Name** | **Specialty** |
| **Address** |
| **City** | **State** | **Zip** |
| **Contact Person** | **Phone** |
| **Email** | **Fax** |

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| **Certification** |
| **I hereby certify that in my medical judgment, the above named patient who has received an adverse determination for the medical services that I have recommended as medically necessary, requires such review to be provided on an expedited basis because a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function or, in the case of an experimental/investigational adverse determination, the recommended health care service or treatment would be significantly less effective if not promptly initiated.** |
| **Provider Signature** | **Date** |

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| **Submit completed form and any supporting documents by:** |
| **Email: QuickCGA@jeffersonhealthplans.com** |
| **Fax: 215-991-4105** |
| **Mail: Jefferson Health Plans** **Member Appeals Department/CGA Unit** **1101 Market Street, Suite 3000** **Philadelphia, PA 19107** |