For Use with Experimental/Investigational Denials Only
To Be Completed by Physician

In my medical opinion as the Insured's treating physician, 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:

   ☐ 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; 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 covered person 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.

Explain:_____

_____

_____

5. ☐ It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Explain:_____

_____

_____

6. ☐ Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. Attach additional sheets as necessary.

_____

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_____ _____

Physician's Signature Date