HIGHMARK WHOLECARE

Certification of Need for Urgent Care Grievance/Complaint

Date of Request:

Highmark Wholecare Member Name:

Highmark Wholecare Member DOB:

Highmark Wholecare ID Number:

Expedited Review for (Service/Item/Issue):

Do you agree that the requested service/item/issue should be an expedited request?

No _____ Yes_____ (if yes, please complete below)

I hereby certify that the usual timeframes (30/45 days) for review about <service/item/issue> may place this patient's life, health or ability to regain maximum function in jeopardy for the following reasons (be specific):

_____

_____

_____

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_____ _____

Physician's Signature **Date**

(Requests will not be processed without a physician's signature)

_____

Printed Name

Fax this completed form along with additional information related to the service/item listed above to the Highmark Wholecare plan at (412)255-4503.

Received by: _____

Date/time: _____ _____

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association (“Highmark Wholecare”).