State Farm
Investigational or Experimental Procedures or Treatment

This form is to be completed by the treating provider as a supplement to the treatment plan for a service or course of treatment that has been or could be determined experimental, investigational, or unproven.

Patient Information			
Last	First, MI	Group Number	Subscriber Number
Health Care Provider			
Treating Provider Name			
Address	City	State	Zip
Contact Person		Phone	
Email		Fax	

Please check the boxes below that apply (all must apply for the member to be eligible for this plan provision):

- ❑ The provider must certify that accepted medical procedures have proven to be ineffective in the treatment of the diagnosed condition and that the condition, if not treated through investigational or experimental means, would be life threatening. Accepted medical procedures are those treatment modalities that meet the definition of Medical Necessity as defined in the State Farm benefit plan;

- ❑ The investigational or experimental treatment must be performed at a facility that has been designated by the appropriate federal regulatory body to perform the procedure;

- ❑ The investigational or experimental treatment must be under an active investigative protocol. Procedures that have been determined to be unproven under an active investigative protocol will not be eligible for payment. This provision does not apply if the diagnosed condition is so rare that an active investigative protocol is not practical; and

- ❑ The expenses must not have been reimbursed or be eligible for reimbursement under any State or federal grant, study, fund, endowment or other public or private funding mechanism.

Information on the scientifically valid studies using accepted protocols should be included with this form.

Please describe the active investigative protocol and indicate the website for information on the protocol.

Please describe the procedure, treatment or drug that is being denied and why you disagree. If medical review has not yet been determined, please describe why this procedure, treatment or drug should not be denied.

I hereby certify that I am the treating health care provider for the patient named above and I have requested the authorization for a drug, device, procedure or therapy denied or could be denied for coverage due to Blue Cross and Blue Shield of Illinois' determination that the proposed therapy is experimental and/or investigational. I understand that in order for the patient to access this benefit provision, as the treating provider, I must certify that the patient's medical condition meets the requirements as shown on this form. In addition, I acknowledge that submission of this form is not a guarantee of coverage or payment and that all provisions of the benefit plan shall apply.

Provider Signature ___________________________ Date______________ National Provider ID__________________________

How to submit this request and supporting documentation:

- **Provider has the ability to complete and submit this form with original request for service along with supporting clinical documents.**
- **Provider has ability to request a Peer to Peer Review. However, Peer to Peer Reviews must be requested prior to appealing a denial. It is recommended that the provider collect the information noted in this form before requesting a Peer to Peer Review.**
- **If provider has already had a Peer to Peer Review prior to completing the attached form, the form will have to be submitted as part of the appeal process.**