



A PATIENT'S GUIDE TO Navigating the Insurance Appeals Process



Solving Insurance and Healthcare Access Problems | since 1996

Dealing with an injury or illness is a stressful time for any patient as well as for their family members.

This publication has been created to help you navigate the appeals process when faced with a denial of coverage or reimbursement for services outlined in your insurance plan. We will provide you information on steps you need to take to file an appeal internally through your insurance company as well as your rights to an external review.

A denial is a “contract dispute,” and your appeal must be based both on the reason for the denial and the provisions in your insurance policy, contract or Summary Plan Description.

It is important to remember that you do have rights which are described in your insurance policy handbook. A health insurance policy is a contract between you, the policy holder, and the insurance company. A denial is a “contract dispute,” and your appeal must be based both on the reason for the denial and provisions in your insurance policy, contract or Summary Plan Description. Support from your treating physician is very important, as they are trained to assess and recommend a treatment plan for you.

This publication is designed to provide a logical approach to the appeal process. When submitting your appeal, keep in mind that the best defense is a good offense. In other words, it is generally better to take the time to gather all the necessary information and submit a thorough appeal packet than to hastily submit a response and miss the opportunity to educate the insurance company about your specific situation.

NOTE: This publication was written by professional case managers at Patient Advocate Foundation to serve as an educational resource for patients seeking an understanding of the process involved in appealing decisions made by a health insurance company. Patients should always refer to their detailed plan language and documentation for authority in their specific situation.

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The Affordable Care Act (ACA) – Appealing a Marketplace Decision

The Affordable Care Act offers a layer of protection by guaranteeing the availability and renewability of health insurance to all individuals. Marketplace plans offer four tiers of healthcare coverage, free from discrimination on the basis of pre-existing health history and gender. Starting in 2014, health insurance plans cannot refuse to cover you or charge you more because of your previous health condition. Coverage of any pre-existing medical condition begins immediately. The Affordable Care Act also gives consumers the right to appeal a decision made by a state or federal health insurance exchange (or Marketplace).

Consumers are guaranteed the right to appeal the following:

- Eligibility to purchase a Marketplace plan
- Eligibility to purchase a plan outside of the regular open enrollment period
- Eligibility for premium subsidies and cost savings (based on household income)
- The amount of cost savings for which you are eligible
- Medicaid or Children's Health Insurance Program (CHIP) eligibility
- Eligibility for an exemption from the individual mandate to enroll in health insurance

After applying for healthcare coverage through the Marketplace, consumers will receive a letter explaining if they qualify for an insurance plan with or without a subsidy or cost reduction benefit, Medicaid or CHIP. The letter will provide information on how to file an appeal of an unfavorable or adverse decision, how to get free help filing an appeal, and how to receive appeal information in a language other than English.¹

Your Appeal Rights When Enrolling in a Plan

The majority of appeals will need to be filed with the state or federal exchange directly, but appeals of decisions regarding Medicaid and CHIP need to be submitted to the state government offices running these programs. After the appeal has been received, the consumer will be sent a letter of acknowledgment that provides more information on the next steps in the process.

During the appeals process, an applicant may be asked to provide documentation or more information related to income and employment. Providing this information in a timely manner will result in a faster decision. Consumers may retain their eligibility status while they appeal a decision.

- You can call the Health Insurance Marketplace Call Center at 1-800-318-2596 for information and appeal forms, including an authorization to appoint a representative who can act on your behalf throughout the appeals process or visit:
[HealthCare.gov/can-i-appeal-a-marketplace-decision](https://www.healthcare.gov/can-i-appeal-a-marketplace-decision).
- You may also contact your state's Consumer Assistance Program (CAP) or Department of Insurance. Visit [LocalHelp.HealthCare.gov](https://www.localhelp.healthcare.gov) to find help in your area.



Understanding Your Illness and Your Insurance Plan

TYPES OF INSURANCE PLANS:

Health Maintenance Organization (HMO)
Exclusive Provider Organization (EPO)
Preferred Provider Network (PPO)
High Deductible Health Plan (HDHP)
Point-of-Service (POS)
Employer-based Self-Funded Plan
Catastrophic Health Insurance Plan
Medicare
Medicaid (*may have an alternate name in your state)
TRICARE Military Plan

You need to understand your condition or your loved one's condition before you can discuss the case with the insurance company. It is very important that you understand exactly what the doctor wants to do and why it is necessary. Read any copies of the letters your doctor may have submitted to the insurance company. The initial letter typically discusses the patient's case in simple medical terms and then explains what the doctor proposes to do. This letter is often referred to as the "treatment plan" or "plan of care". You can ask your doctor or nurse to explain it further. Often they may have written material that may be helpful, or they may be able to direct you to find more information.

In addition, it is important for you to be familiar with the type of insurance you have and how it is administered. Depending on the structure and funding of your plan, you may have additional options during and following the appeal process beyond the options outlined in your plan language.

If your insurance is coordinated through a workplace employer contact the human resources representative and ask him or her to explain the coverage policies and nature of the plan structure. The human resources person can provide clarity information on the process for appeals, can answer questions about your coverage details, can assist with paperwork or provide a connection to a representative for the insurer to formally begin the process.

If your plan is sponsored by a large corporation, or one that has alerted you that they "self-fund" their health insurance benefits, this means that the employer may maintain influence in the ultimate



decisions made on payment of medical claims and healthcare decisions related to the plan language. Although your company has likely contracted with a third-party organization to manage the plan, in essence, the company sponsoring the plan can make decisions as your medical insurer.

For self-funded plans, it is beneficial to keep the human resources and/or internal insurance personnel at the company aware of your appeal intentions and inform them about the insurance barriers you are experiencing and how this is impacting your healthcare. The human resources staff can, in some situations, put enough pressure on key decision makers to have a denial reversed or influence a favorable outcome for you.

Knowing Your Rights as a Consumer

The Affordable Care Act (ACA) ensures your right to appeal health insurance plan decisions. Under this law, if you disagree with your insurance plan's refusal to approve or pay for care, you have the right to appeal through the health plan's internal process, which may involve several levels of appeals. Your health plan cannot drop your coverage or raise your rates because you ask them to reconsider a denial. This may involve a request for pre-authorization of a service or claim for services already rendered.²

Your plan must notify you of:

- The reason your claim or coverage was denied
- Your right to file an internal appeal with instructions on how to submit
- The deadline in which you need to submit your appeal
- The availability of a Consumer Assistance program (in some states)³

If you are not satisfied with the insurance plan's final response, the Act allows for an external review process. An external review is a review of the health plan's decision by an independent third party. An external review (or appeal) will either uphold the insurance company's decision or decide in favor of the consumer by overturning all or part of the health plan's decision.

YOU HAVE RIGHTS!

Now your right to appeal a decision made by your insurance company to ask for reconsideration without backlash is guaranteed.

LOOK FOR IT!

Did you know that every claim document sent from your insurance company **must** outline your appeal rights and the appeal process?

QUICK TIP:

Think of an appeal as a contract dispute over interpretation of the plan coverage details. Your plan language defines your contract.

2 - <http://www.healthpocket.com/affordable-care-act/appealing-marketplace-decisions>

3 - *Appealing Health Plan Decisions*, 10/29/2013

<http://www.hhs.gov/healthcare/rights/appealappealing-health-plan-decisions.html>

Federal Laws and State Departments that May Influence the Appeals Process

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most non-governmental health plans to provide protection for individuals in these plans. ERISA requires that participants insured by most group health plans are informed of the processing of benefit claims, your rights when a claim is denied, and the timeline for a decision when you file an appeal. ERISA does not apply to some employee benefit plans such as those sponsored by government offices and most churches. Insurance plans that are purchased in the individual market are likely to be non-ERISA plans and are regulated by the State Department of Insurance.⁴

YOU CAN CONTACT YOUR STATE DEPARTMENT OF INSURANCE IF:

- 1) You have a grievance against a licensed health insurer.
- 2) You wish to learn more about the external review process.
- 3) You would like to know more about the availability of a Consumer Assistance Program.

You can find contact information for your State Department at www.naic.org/state_web_map

Support for Your Appeal from a Consumer Assistance Program

Many states have established consumer assistance programs to help with appeals and to help you understand your health insurance rights. Your letter from the insurance plan should give you contact information for the consumer assistance program in your state or you can call your state insurance department; they can provide contact information for the consumer assistance program in your state. You may also visit the Center for Consumer Information and Insurance Oversight at www.cms.gov/CCIIO, they work closely with state regulators and consumers to ensure the needs of the American people are being served. If you are a participant or beneficiary in an employer-sponsored health plan contact the Employee Benefits Security Administration, U.S. Department of Labor at www.askebsa.dol.gov or call 1-866-444-3272.

Beginning Your Appeal

Before you can request an appeal, something must be denied, a service, payment or coverage. The first thing to do is call your insurance company; the number should be on your insurance identification card. The purpose of your call will be to learn the reason for the denial, and whenever possible, find a way to resolve the issue in a timely manner.

Use detailed and organized documentation. Be sure that you keep track of:

- ☒ The dates and method of any correspondence (by phone, email, in writing)
- ☒ The names of insurance agents and claim reviewers with whom you speak, and
- ☒ Summaries of your conversations and written documents issued by your insurer.

Even when dealing with the stress of an illness, being courteous and polite when dealing with your insurance company always serves you best.



Identifying the Reason for the Denial

Your health insurance plan must notify you in writing of the reason they did not authorize a specific request or denied payment of a service as well as how to appeal their decision. Some of these reasons include:

- Services are deemed not medically necessary
- Services are no longer appropriate in a specific health care setting or level of care
- Services are considered experimental or investigational for this condition
- The effectiveness of the medical treatment has not been proven
- You are not eligible for the benefit requested under your health plan



Important Information to Submit with Your Appeal

- A **letter of support** from your treating provider indicating the medical reasons that the requested service should be approved
- **Notes** from your treating physician that provide information on the medical care provided to you including how you responded to treatment
- The **results** of any relevant tests or procedures related to the requested service
- Any **current medical literature** or studies documenting the medical effectiveness of the requested services for experimental or investigational treatments
- **Peer reviewed articles** from your doctor's professional journals or magazines that support the treatment being recommended
- Your own **personal narrative** or the narrative of an authorized representative describing the need for the requested service

**A useful online resource is
www.pubmed.gov**



Your Appeal Letter – Tips on How to Achieve a Successful Claim Resolution

One of the most important elements of your appeal packet is a clear, concise letter that addresses very specifically the reason of the denial, and incorporates the terms of your policy (or plan language). Your physician or his office staff may choose to write the letter on your behalf, but if you are writing your own, here are a few thoughts to consider:

- Describe your medical condition and the impact it has had on your life. State plainly why you need the prescribed medical service, be pleasant and brief and do not convey any frustration you may have with regard to the refusal of benefits.
- State the reason(s) you believe your insurance policy covers the treatment/service.
- Use your own words, not legal terminology or other phrasing.
- If you are appealing only part of the denial, state the part you are appealing.
- Present whenever available convincing evidence or cost comparison information that the prescribed medical service will save the insurance company on future expenses, such as the management of side effects or readmissions to the hospital.
- Provide clinical data, such as published journal articles or data on outcomes, which shows the benefits and success of the prescribed treatment/service.
- Include contact information for both you and your doctor.
- Ask your doctor to review your appeal letter and make any necessary revisions. You may want to submit your physician's letter at the same time that you submit your own in order to strengthen your argument.
- Send the letter by certified mail with a request for a return receipt.
- Keep a copy of the letter, the delivery receipt and a record of all correspondence prior to and following the mailing of your appeal.

Request a timely response from your insurance plan based on the guideline that your plan must follow. Insurance companies are required to respond to a written appeal letter and you should receive a notice within 7-10 days that your appeal packet has been received. If you do not receive confirmation from your insurance company, contact your insurance company representative to make sure your appeal was received.

What if My Appeal is of an Urgent Nature?

Insurance companies are required to have a process in place for handling appeals that are of an urgent nature. You, or your authorized representative, may file an **expedited appeal** request with your health plan verbally. Your insurance company must make a decision within 4 business days from receipt of the appeal.

You can request an urgent or expedited appeal if you:

- Are currently receiving or you were prescribed to receive treatment; and
- Your medical provider believes a delay in treatment could seriously jeopardize your life or overall health, affect your ability to regain maximum function, or subject you to severe and intolerable pain; or
- If your issue is related to an admission or continued inpatient stay and you have not yet been discharged.

You cannot file an expedited appeal if you:

- Already received the treatment and disagree with a claim denial, or
- Your situation is not considered to be urgent by a medical provider with knowledge of your medical condition or the medical director of your insurance plan.

Your health plan must respond as soon as possible, usually within 24 hours, but no longer than 72 hours. The plan may deliver the decision verbally, but a verbal decision must be followed in writing within 72 hours.

Types of Appeals

Apart from an appeal for coverage or benefits through the newly established Health Insurance Marketplaces (described on page 2 and 3 of this guide), there are generally three types of insurance appeals:

Type of Appeal	Details	Timeline for Patient Submission of Appeal Documents	Timeline for Decision & Response from Insurer
Pre-Service (or Pre-Authorization) Appeal	Your plan has denied a submitted request to obtain medical services BEFORE you were given care. The denial has prevented you from receiving the care you have been prescribed.	SUBMIT YOUR APPEAL WITHIN DEFINED TIMELINE SPECIFIED ON YOUR ACTUAL DENIAL LETTER	Decision within 30 days from initial submission of appeal documentation
Post-Service Appeal	Your plan has denied a claim for reimbursement or payment of a medical procedure, meaning you are 100% responsible for any charges.		Decision within 60 days
Urgent Care (or Expedited) Appeal	You have requested that your appeal documents be examined in a timely manner because of medical necessity.		Decision within 72 hours after receiving the appeal
Marketplace Plan Appeal	The Affordable Care Act gives you the right to appeal a decision made by a state or federal health insurance exchange. This may include decisions surrounding eligibility for specific plans or financial assistance.		Within 90 days of submission

Steps in the Appeals Process

Depending on the state in which you reside and your specific insurance plan, there are typically three levels of insurance appeals. If your claim is denied due to a particular service being billed or coded incorrectly, your physician's support staff may be able to gather and submit the necessary information on your behalf, in order to resolve the issue without the necessity of a formal appeal.

■ **First Level Appeal or Request for Reconsideration**

You or your health care provider may contact your insurance company and request reconsideration. Your physician may also request to speak with the medical reviewer of the insurance plan as part of a “peer-to-peer review” in order to challenge the decision which could resolve the issue. The purpose of the first appeal is to prove that your post-service claim or request for pre-authorization DOES meet the insurance guidelines and that it was incorrectly rejected.

- **Second Level Appeals** are typically reviewed by a medical director of your insurance plan who was not involved in the claim decision. The goal of this appeal is to prove that the request should be accepted within the coverage guidelines. There may be an additional level of appeals to determine if the medical care or service is experimental or investigational.

- **Independent External Reviews** are conducted by an independent, third-party reviewer in collaboration with a physician who is board-certified in the same specialty as the patient's physician.





What are Your Rights in an External Review?

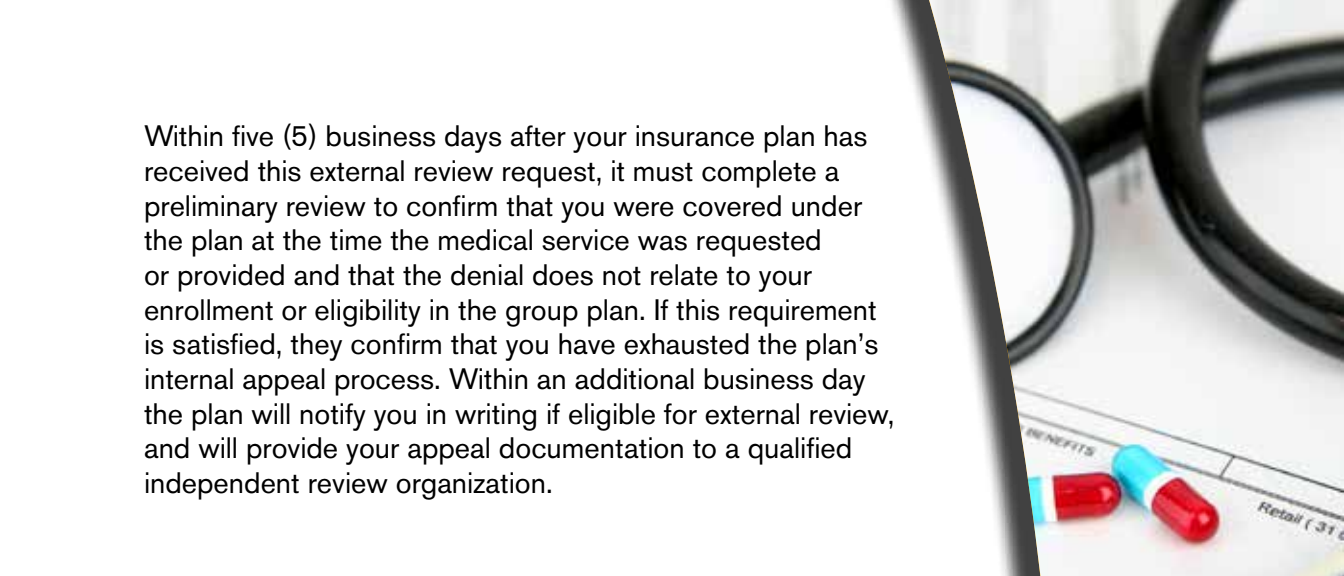
Effective January 1, 2012, health insurance issuers in all states must participate in an external review process that meets minimum consumer protection standards as outlined in the Affordable Care Act. Your state may have an external review process that meets or goes beyond these standards. If so, health insurers in your state will follow your state's external review processes and you will benefit from all of the protections outlined in that process.

If your state does not have an external review process that meets the federal minimum:

- The services you request must be covered under your plan.
- Requests for external review must be for services that are provided under your insurance plan.
- If services are denied because they are not a covered benefit under your plan or your benefits for these services have reached their limit, then the grievance process is concluded after your first internal appeal. No further appeal or option to have an external review is allowed under the plan.⁵

Most health plans must allow you (as claimant) to file a request for an external review if the request is filed within four (4) months after you have received the final insurance denial of your claim in writing (termed an adverse benefit determination).

Your group health plan must also allow you to make a request for an expedited external review when the time for completion of a standard external review would seriously jeopardize your life, health, or ability to regain maximum function. It must also expedite your review if the final adverse determination concerns a hospital admission, availability of care, or continued stay for which you received emergency services, but have not been discharged from the facility.



Within five (5) business days after your insurance plan has received this external review request, it must complete a preliminary review to confirm that you were covered under the plan at the time the medical service was requested or provided and that the denial does not relate to your enrollment or eligibility in the group plan. If this requirement is satisfied, they confirm that you have exhausted the plan's internal appeal process. Within an additional business day the plan will notify you in writing if eligible for external review, and will provide your appeal documentation to a qualified independent review organization.

Referral to an Independent Review Organization

Your health plan must involve an unbiased, accredited organization that does not receive financial incentives to review your case. The organization assigned to your review is not bound by any decision reached during the plan's internal review process. Your insurance plan must provide the IRO with any documents that were used to make their final adverse determination, within five (5) days of you receiving notification that the IRO has accepted your review.

The Independent Review Organization considers the following as appropriate:

- Your medical records
- Your attending physician's recommendations
- Reports from appropriate health care professionals and other documents submitted by your plan, and statements issued by yourself and your treating provider
- The terms or language of your health plan
- Appropriate practice guidelines
- Clinical review criteria developed and used by the plan

After the IRO has received the initial request for external review it must provide written notice of the final decision within 45 calendar days. If the decision was to reverse or overturn your plan's denial of benefits, the plan must immediately provide coverage or payment for the claim. In cases involving an expedited external review, IRO must notify the patient as to the decision as quickly as your medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for expedited review.

Independent Review Organization (IRO):

an unbiased, accredited organization that does not receive any financial incentives to review your case.

A list of accredited IROs can be found at:
www.urac.org/directory/DirectorySearch.aspx
(Search under Module for Independent Review Organization: External Review).

What if My Appeal is Unsuccessful and I Have Exhausted My Appeal Rights?

At this point, if you have exhausted all the levels of appeal and are not satisfied with the decision, your remaining alternative may be to pursue the issue in court. Otherwise, if the final decision was to uphold the insurance plan's denial for treatment you already received, you will be responsible to pay any charges. If the decision involves a pre-authorization for a medical service you have not yet received, you can check with your treating provider about available discount assistance programs such as prompt-pay discounts, self-pay discounts, or reasonable payment arrangements. When you are negotiating a discounted rate, you want to utilize resources that provide a "cost calculator" for common procedures.

Some facilities offer Care Credit as an option. This is a special category of personal (unsecured) credit where you have a specific period of time, up to 18 months, to pay the bill without any finance charges. Many hospitals will not extend payment plans past 12 months. Care Credit offers an option that may make payments affordable.

If you applied and are successfully awarded financial assistance through the hospital, check with your other providers, as they may be willing to match the discount provided by the hospital. Be aware, however, they are not obligated to do so. You will need to contact the billing office of each facility to explain your circumstances and present any documentation of assistance you have already been given. It is important to contact your providers and establish some kind of arrangement to avoid having bills sent to collections.

Appeals for Services Received Outside Your Insurance Network

Before seeking care outside of your network providers, you want to determine if your plan allows any out-of-network coverage. If you have received a denial of care or a claims denial because you sought care from an out-of-network provider, you can attempt to have the original decision overturned through an appeal. More “open-ended” plans, or Preferred Provider Organizations (PPO), allow you to pursue care outside of your insurance network at increased deductibles and out-of-pocket costs. However, Health Maintenance Organizations (HMO) plans, only pay when members utilize in-network providers.

In some instances, such as when there is no suitable local in-network provider, you may win an appeal forcing your plan to reimburse the medical service(s) at an in-network rate. Confirm that there were no in-network providers in the area where you sought health care services. Most health plans have rules that state if there is no provider within a certain number of miles from your home you can see an out-of-network provider at the in-network coverage rate. However, even if your insurer chooses to cover the service(s) at an in-network reimbursement rate, the provider may not consider this payment in full and you can be held responsible for the difference.

Ask the out-of-network provider if they will write a letter on your behalf explaining why your plan should reimburse for services in the case of a HMO or at the in-network rate in the case of a PPO. If the provider is a specialist and there are no other specialists of his kind in the network, you may have a good argument. Gather any supporting document that shows why you should have this care approved and the original determination overturned.



Sample Appeal Letters

Each
patient–
and each
denial–is
unique.

The Sample Appeal Letters included in this guide are designed to be a general guide for your specific letter.

Sample Appeal Letter A was written to address a denial based on the question of medical necessity.

Sample Appeal Letter B addresses the issue of a denial based on receiving out-of-network care.

Sample Appeal Letter C references several scenarios resulting from a lack or denial of pre-authorization.

There is a **Physician's Sample Appeal Letter** which is a general template and must be tailored to the patient's situation and demonstrate sufficient medical necessity for the service, procedure, or therapy involved.

It is recommended that you read each sample letter presented and then identify other important details that need to be added to your letter to complete your request.



Sample Appeal Letter A

ADDRESSING MEDICAL NECESSITY

Date

Insurance Company Name
Insurance Company Address
Insurance Company City/State/Zip

**SEE PAGE 20 FOR
INSTRUCTIONS ON
FILLING OUT
THIS LETTER**

Re: Request for reconsideration of coverage denial.
Your Name
Type of Insurance
Group/Policy Numbers
Subscriber ID Number

Dear [name of representative] or Claims Review Department,
After consulting with my physician, [doctor's name], I have decided to appeal your decision to deny coverage of [his/her] recommended treatment plan for [enter the name of type of surgery or treatment your doctor has recommended that was denied by your insurance company].

Your letter dated [date of letter] stated that "[quote the exact reasons for denial from the letter]".
On [date], Dr. [name] diagnosed me with [diagnosis]. [If you have obtained any other medical opinions that confirm this diagnosis, list those physicians, also. List any diagnostic test, such as an MRI, x-ray or CT scan, that was used by your doctor to reach this diagnosis]. This serious medical condition has [describe how your medical condition has affected the quality of your everyday life, the level of pain and disability you are experiencing, your ability to work and any other effects]. Since [date], I have tried various other treatments for my condition. These include: [list treatments, surgeries, non-surgical therapies and medications].

I am greatly encouraged that my doctor believes I am a good candidate for [name of surgery or treatment that was denied coverage]. [He/she] also believes I will have significant relief from [name what the treatment will do for you, such as relieve pain] after the [name of surgery or treatment that was denied coverage] and will be able to eventually discontinue [list therapies, medications and other medical treatment your insurer is currently paying for]. Please read Dr. [name]'s Letter of Medical Necessity which is included in this packet. In this letter, Dr. [name] describes my medical history, diagnosis and the rationale used in determining that I should have [name of surgery or treatment that was denied coverage]. [name of surgery or treatment that was denied coverage] has been [pick appropriate descriptions: approved by the FDA, proven to be safe and effective, proven to have an extremely low complication or re-admission rate, considered a covered treatment by Medicaid, Medicare and the following private payers: (name insurers)].

I am confident in Dr. [name]'s experience in performing (recommending) this [surgery/treatment]. [He/she] is [doctor's credentials, such as board certification in a given specialty field of medicine, any professional titles such as medical director, any special training in this specific procedure] and has performed this procedure since [date] in more than [number] surgeries. Please contact Dr. [name] or me if you need more information about the efficacy, safety and effectiveness of the [name of surgery or treatment that was denied coverage]. For your information, I have attached peer review studies, clinical studies and articles from scientific journals regarding this procedure.

I look forward to hearing from you by [date that is within the insurance policy's guidelines]. My contact information is listed below.

Sincerely,
Your Name
Your Street Address, E-mail Address, Phone Number, Fax Number, Cell Phone Number

cc: Doctors' Names
Employer's Name

Enclosures: [Provide a list of everything in your appeals packet].
Include a Statement of Medical Necessity from your medical provider.

You must always remain factual and write clearly.

How to use these letters for your own appeal:

- 1) **Choose the sample letter format that best matches** the denial reason identified in your insurance company's denial letter. (If the reason cited does not match one of these samples, you may have to draft an original letter to present your case.)
- 2) For each of the areas of the sample letters identified with **a bracket [] and red text, replace with content that matches your specific medical and health issue.** You may need to adjust the suggested language slightly to match the details you added so that the letter reads smoothly.
- 3) If the sample letters have provided more than one option within the text, **choose the ONE that best matches your situation and delete the others from your letter.**
- 4) **Be sure to input your personal contact information in the opening and closing portions,** including policy number, name, home address and phone in the areas suggested. Sign the letter with your signature in blue or black ink.
- 5) **Have someone read over your letter for typos and grammar errors** before you send to insurance company. All []'s and instructions should be removed at this point.
- 6) **Spell check your document,** but be careful not to automatically correct medical terms or doctor's names.
- 7) **Make copies for your files** and send original documents according to the appeal instructions in your denial letter.

Sample Appeal Letter B

**SEE PAGE 20 FOR INSTRUCTIONS
ON FILLING OUT THIS LETTER**

ADDRESSING OUT OF NETWORK CARE

Date

Insurance Company Name
Insurance Company Address
Insurance Company City/State/Zip

Re: Request for reconsideration of coverage denial for Out-of-Network services (this may also involve a request for an in-network reimbursement rate).

Your Name
Type of Insurance
Group/Policy Numbers
Subscriber ID Number

Dear [name of representative] or Claims Review Department,

I am writing to you in regards to a claim submitted by [medical provider] for [patient]. The charges were rendered on [date] and totaled [claim dollar total]. [Health plan] has denied payment for this medical procedure stating that it was out of network and not payable.

OPTION 1 *(choose the best paragraph out of these three options that applies to your situation)*

I went to a facility/physician that was out of network because there was not an in-network facility/physician who could offer me the appropriate medical treatment needed for my care. I exhausted a great deal of effort in searching for an in-network facility/physician that could perform a similar service, but was not successful.

OPTION 2

I went to a facility/physician that was out of network because there was not an in-network facility/physician in my geographical area that could assist me. I exhausted a great deal of effort in searching for an in-network facility/physician that could perform a similar service, but was not successful.

OPTION 3

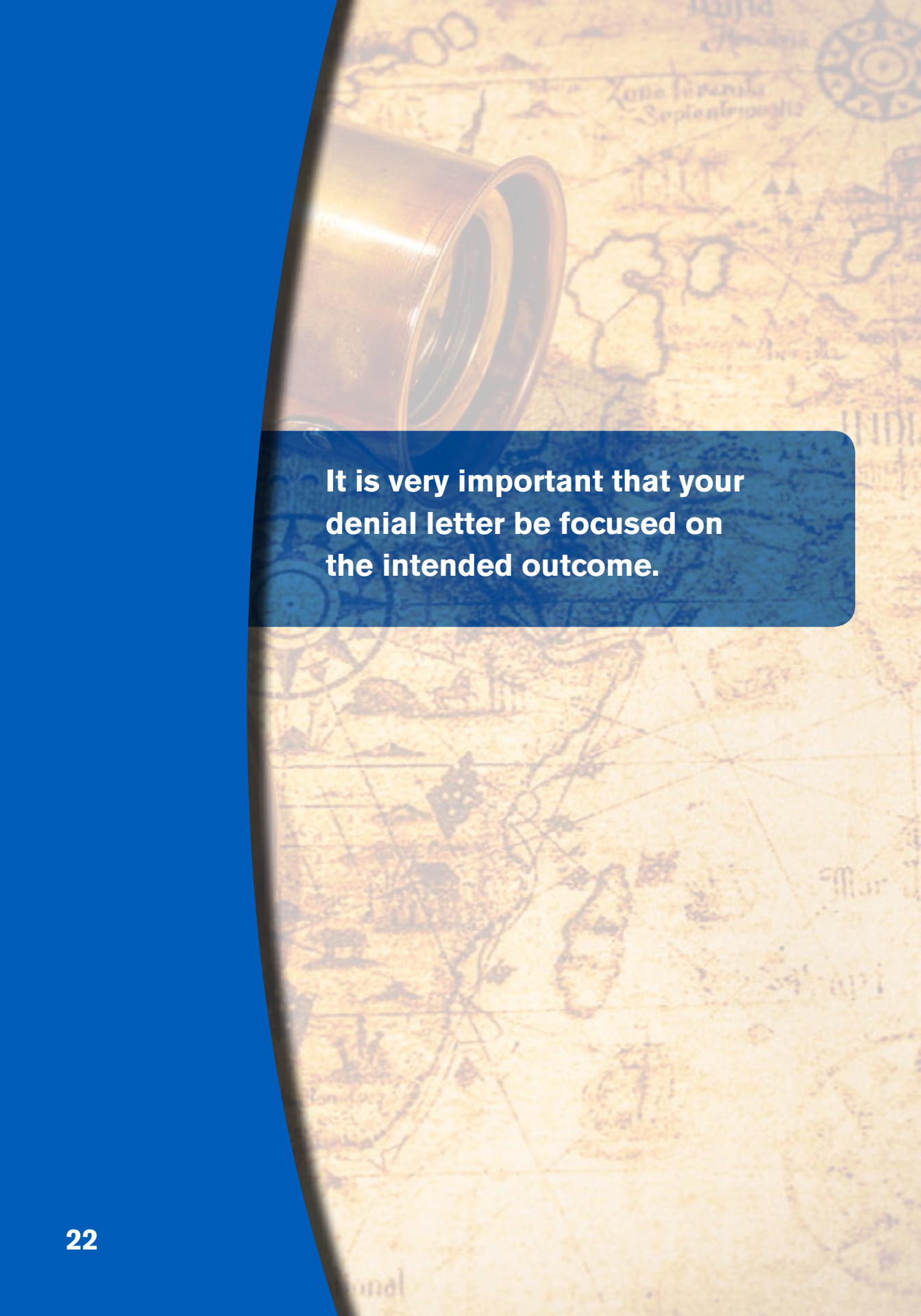
I went to a facility/physician that was out of network because it was an emergency situation, it was medically necessary, and there was not an in-network facility/physician in my geographical area that could assist me.

I feel that I should not be penalized for having received treatment which was medically necessary. My medical provider has included a letter of medical necessity stating that the procedure and treatment [he/she] performed was appropriate and medically justified. [Furthermore, this medical provider is willing to accept a negotiated fee for the service performed—Add only if confirmed]

There is no question that [the medical procedure] was medically necessary, and I hope you reconsider your denial and pay for all of my outstanding claims associated with this procedure. Thank you for your time and assistance in this matter.

Sincerely,
Your Name
Your Street Address, E-mail Address, Phone Number, Fax Number, Cell Phone Number

Enclosures:
A statement of medical necessity from your medical provider



It is very important that your denial letter be focused on the intended outcome.

Sample Appeal Letter C

**SEE PAGE 20 FOR INSTRUCTIONS
ON FILLING OUT THIS LETTER**

LACK OF AUTHORIZATION

Date

Insurance Company Name
Insurance Company Address
Insurance Company City/State/Zip

Re: Request for reconsideration of coverage denial due to lack of pre-authorization.

Your Name
Type of Insurance
Group/Policy Numbers
Subscriber ID Number

Dear [name of representative] or Claims Review Department,

I have received a denial on claims submitted on my behalf with the explanation that it was being denied due lack of authorization.

OPTION 1 *(choose the best paragraph out of these three options that applies to your situation)*

[Patient name] was admitted to [facility name], which is an in-network facility with my health plan. My primary care physician [physician name] is a participating provider. As members of this plan, they should know the requirements of my plan and obtain the authorization, if one was required for my [treatment or inpatient stay]. However, if one was not obtained, it should not be my responsibility and I should not be penalized for their inactions.

OPTION 2

[Patient name] was admitted to [facility name] and treated in the Emergency Room. As a result of the emergency situation and severe illness/injury, [patient name] did not have an opportunity to obtain an authorization from [health plan] prior to [treatment or inpatient care]. [patient name] did attempt to contact [health plan] on [list date and time], which was the first opportunity to obtain the authorization.

OPTION 3

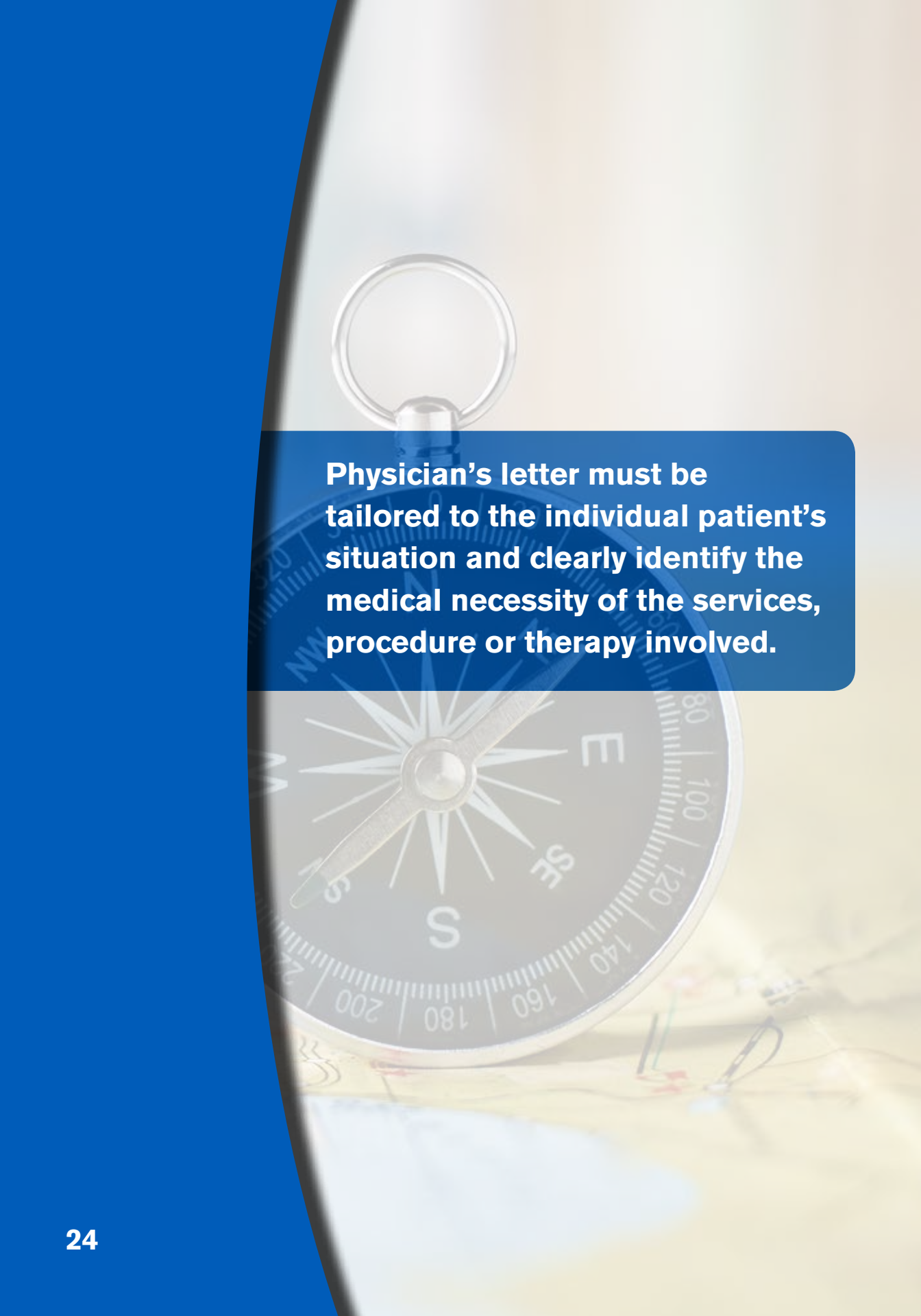
[Patient name] was admitted to [facility name] and treated for [list medical condition or illness]. I have contacted [facility name] and they did obtain an authorization for these services. The authorization number is [list authorization number].

I am requesting that you take this information into account and waive any policy provision and overturn your denial of the claim. Additionally, the treatment I received while I was inpatient was medically necessary and I am prepared to have my physician provide a statement of medical necessity and submit medical records to justify the reason for my stay.

Please reconsider my claim with the information obtained in this appeal letter. Thank you for your time and assistance, and I look forward to your prompt response.

Sincerely,
Your Name
Your Street Address, E-mail Address, Phone Number, Fax Number, Cell Phone Number

Enclosures:
Statement of medical necessity if requested



Physician's letter must be tailored to the individual patient's situation and clearly identify the medical necessity of the services, procedure or therapy involved.

Physician's Sample Appeal Letter

**SEE PAGE 20 FOR INSTRUCTIONS
ON FILLING OUT THIS LETTER**

Date

Insurance Company Name
Insurance Company Address
Insurance Company City, State ZIP

Re: Patient's Name
Type of Insurance
Group/Policy Numbers
Subscriber ID Number

Dear [name of contact person at insurance company],

It is my understanding that [patient's name] has received a denial for [name of procedure] because the procedure is [state specific reason for the denial i.e. not medically necessary, experimental, etc.].

As you know, [patient's name] has been under my care since [date] for the treatment of [state disease]. [Give a brief medical history emphasizing the most recent events that directly influence your decision to recommend the denied therapy.] For this reason I am writing to provide you with information regarding [name of procedure/treatment]. [Give a brief, yet specific description of the procedure/treatment and why you believe it should be approved]. I have also included several journal articles supporting the use of [name of procedure/treatment] for [patient's name] [name of disease].

I ask that you reconsider your previous decision based on the information above. Should you have any questions, please do not hesitate to call me at [phone number].

Sincerely,
Your Name
Your Street Address, E-mail Address, Phone Number, Fax Number, Cell Phone Number

Enclosures:
Statement of medical necessity if requested
Journal or peer literature supporting the service in question

When to Consult an Attorney

This is an important question and one that is asked frequently. There is no right or wrong answer. Many people feel more secure discussing their case with an attorney when they receive a denial.

Others would rather appeal the decision on their own to see if they can have the decision reversed without seeking legal assistance. For some it depends on the cost of the procedure which has been denied. It may make more sense to seek legal advice if the procedure costs \$100,000 than if the procedure costs \$1,000. As previously mentioned, if you do not understand the appeal process or you are unable to get answers from your employer or insurance company, an attorney may be helpful to advise you of your rights and options.

If you decide to seek legal advice you should consider the following:

- Select an attorney with experience in healthcare law. Visit Martindale.com to search for an attorney specializing in healthcare.
- Discuss the legal fees up front and request a detailed billing.
- Determine at what point the attorney will take over the case.

Whichever way you decide to proceed, the decision is yours to make.

Seeking legal assistance is an individual decision.



Notifying Elected Officials

Insurance and patient rights is a hotly debated political issue.

Patients often ask if it is helpful to notify their state and local representatives of their insurance issues. In some cases it has been helpful. Other times, patients get nothing more in return than a form letter stating there is nothing their legislator can do.

You may choose to approach this question by asking yourself, "What do I have to lose?" You are already preparing your own appeal letter. You could easily send a copy of the denial letter along with your appeal letter to your legislators asking for any assistance they can provide.







The background of the page is a composite image. On the left, there is a close-up of a vintage compass rose with colorful, weathered points in shades of green, orange, and white. To the right, a large lighthouse with a white body and a dark, spiraling band is visible, set against a clear blue sky. The lighthouse is partially obscured by a large, solid blue shape that curves from the top right towards the bottom left, creating a modern, graphic design.

PAF Patient Advocate Foundation

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www.patientadvocate.org/gethelp