

UNDERSTANDING HEALTH CARE BILLS

How to Appeal Denied Claims



When you use medical services, you or your provider file a claim to your health plan. Most of the time, the health plan will pay the claim, either directly to the provider or to you if you have already paid for your medical care.

Sometimes your health plan will say “no” to a claim, in full or in part, for benefits or services you believe should have been covered. Here are the steps you can take:

... If Your Health Plan Says “NO”

You have the right to appeal your health plan’s denial of benefits for covered services that you and your health care provider (doctor, hospital, etc.) believe are medically necessary.

There are two kinds of appeals—**internal appeal** and **external review**

Filing an Internal Appeal

By filing an internal appeal, you are requesting your health plan to review the denial decision in a fair and complete way. You have up to six months (180 days) after finding out your claim was denied to file an internal appeal.

- If the denial is for a medical reason, ask your health care provider to contact your health plan to request reconsideration of your claim based on additional information that your provider can supply.
- If your life, health, or ability to function could be jeopardized, you can request that the appeal be reviewed on an expedited basis.

- Ask your health plan how to file an internal appeal by contacting the customer service number provided on your insurance card /materials, or
- Write a letter to your health plan requesting an internal appeal. Make sure to include your name, claim number, and health insurance ID number. You should include any additional information, such as a letter from your provider, that helps support your claim. (See next page for sample letter.)

Upon receiving your request, your health plan has a specific amount of time to review and issue a decision on the internal appeal.

... If Your Health Plan Still Says “NO”

Filing an External Review

If your health plan does not change its decision as a result of the internal appeal, an external review can be requested. An external review is performed by an independent review organization. You must ask for an external appeal within a specific amount of time after receiving the decision of your internal appeal.

- Your internal appeal notice should provide information on requesting an external review.
- Your state’s insurance regulatory agency is usually in charge of the external review process.
- New information can be submitted to support your position.
- The external reviewer will provide you and your health plan with written notice of its decision within a specific amount of time after receiving the review assignment.
- If the external review results in a reversal of your health plan’s decision to deny, the company must approve benefits for the covered services.

If you have questions or think your health plan is doing something wrong, contact your state insurance regulatory agency. A directory of all state insurance regulatory agencies is available at naic.org.





Sample letter to request an internal appeal

Your Name

Your Address

Date

Address of the Health Plan's Appeal Department

Re: Name of Insured

Plan ID#:

Claim #:

To Whom It May Concern:

I am writing to request a review of your denial of the claim for treatment or services provided by *name of provider* on *date provided*.

The reason for denial was listed as (*reason listed for denial*), but I have reviewed my policy and believe *treatment or service* should be covered. *Here is where you may provide more detailed information about the situation. Write short, factual statements. Do not include emotional wording. If you are including documents, include a list of what you are sending here.*

If you need additional information, I can be reached at *telephone number* and/or *e-mail address*. I look forward to receiving your response as soon as possible.

Sincerely,

Signature

Typed Name

Things to Keep in Mind



Medicare & Medicaid

If you are enrolled in Medicare or Medicaid, there are different rules for appeals.

- For **Medicare**, call 1-800-MEDICARE to ask for information on free assistance.
- For **Medicaid**, contact your state's Medicaid agency for assistance.

Keep Records

Keep detailed records, including bills from your provider, notices from your health plan, copies of denial letters, appeal requests and medical information related to your case.

Take Detailed Notes & Establish Response Deadlines

Write down the date/time of all calls, names of people with whom you spoke, details of all conversations and any established deadlines for expected responses or information from your insurance company.