

Dear [Appeals Analyst]:

I am writing, on behalf of [name of plan member if other than yourself], to appeal the [name of health plan and policy number] decision to deny [name of service, procedure, or treatment sought] for [name of plan member if other than yourself].

It is our understanding that [name of health plan] is denying coverage on the basis that "[cite health plan's language in the denial letter]." [Attach denial letter.] We believe that [name of service, procedure, or treatment sought] is medically necessary to treat [name of plan member if other than yourself]'s medical condition and that [name of service, procedure, or treatment sought] is a covered plan benefit.

[Name of health plan] covers medically necessary services that are not expressly excluded, which are described in the Evidence of Coverage and which are authorized by the member's PCP and in some cases approved by an authorized reviewer. [Attach relevant section from Evidence of Coverage.]

The entire treatment team has recommended that [name of service, procedure, or treatment sought] is medically necessary. [Attach supporting medical letter.]
Contrary to your letter, [name of service, procedure, or treatment sought] is a covered service.

[Name of service, procedure, or treatment sought] is stated as a covered benefit in your [title of member handbook], is implicitly covered in the Evidence of Coverage, and is not expressly excluded as a covered service in the Evidence of Coverage. [Quote from member handbook and Evidence of Coverage to establish that the service, procedure, or treatment is a covered benefit and not expressly excluded.] [Cite your state's mandated benefit laws requiring that the health plan provide this coverage.]

[Describe member's health condition, and why the service, procedure, or treatment would benefit the member and what will happen if the patient does not receive this treatment.]

[If the treatment is out-of-network, establish that there are no comparable services offered within the network.]

[Finally, if you feel they won't cover the service because of the precedent, ask them to consider covering it as an extra-contractual benefit, and to pay for the service, procedure, or treatment out of the health plan's catastrophic payment pool.]

[If the member requires immediate treatment for the condition, request an expedited hearing – request that they respond within the required 72 hours of mailing of the letter. Note that this time frame is required for plan years or policy years beginning on July 1, 2012.]

[Attach a letter from your treating physician describing the person's condition.]

Thank you for your immediate attention to this matter.

Sincerely,

[Your name]

cc: [Possible people to whom you should consider sending copies of your letter, such as:]

[Health Plan Medical Director]

[Medical Group Medical Director]

[Your primary care or treating physician]

[Your state representative if you expect more denials]