Health Insurance Appeals

An appeal is when you ask your health insurance company to reconsider their decision. Health insurance plans must tell you why they did not cover services.

Steps for the Appeal

Step 1	• Know Your Insurance Plan
Step 2	• Understand the Denial
Step 3	• Know Your Appeal Rights
Step 4	• Gather Documents
Step 5	• Write an Appeal Letter
Step 6	• Submit Your Appeal

Tips for the Appeal

- Pay attention to appeal deadlines for when the appeal is due. Mail your letter certified. This step will give you proof that you sent the letter before the deadline.
- Stay organized with a calendar or contact log. You should document your communications and important dates.
- Make copies of your appeal packet.
- You can request an expedited review of your appeal if you or your child need a treatment or procedure right away.

Sample Appeal Letter

The next page has a sample letter that you can use when you need to file an appeal to your health insurance plan. You will need to include your own information.

[Date]

[Health Insurance Plan Name]
[Appeals and Grievances Department]
[123 Street Address]
[Town/City, IL, 12345]

RE: [Patient's Name]
[MEMBER ID Number]
[Reference Number on Explanation of Benefits]
[Date of Birth]

RE: [Policy Holder's Name]
[MEMBER ID Number]
[Reference Number on Explanation of Benefits]
[Date of Birth]

To Whom it May Concern at **[Insurance Company Name]**:

My name is **[your name],** and I am a policyholder of **[insurance company]**. My child's name is **[child name]**. I wish to file an appeal to **[health plan name]** for the denial of **[procedure or service description]** for my child. I received an Explanation of Benefits dated **[date]** stating **[provide denial reason directly from letter]**.

My child was diagnosed with **[diagnosis]** on **[date]**. **[Here include a brief description of the condition and how it impacts your child's life. This should relate to the services that you are appealing]**. My child is seen by **[doctor name]** at **[provider/facility name]**. In the Letter of Medical Necessity, which is included, **[doctor name]** explained why **[service or treatment]** is necessary for my child. I have also

included other documents **[list types of documents]** that explain why my child needs this care**. [list any other services/treatments/procedures that have been tried]**. If **[procedure/service]** is not approved, **[explain what will happen if your child does not get these services]**.

Please review the included documents and reconsider the previous denial decision to allow coverage of **[procedure]**, as this treatment is necessary to my child's health.

If there is any other supporting information you need to approve these services, please do not hesitate to contact me at **[your phone number]** or my physician at **[doctor's phone number]**.

Thank you for your attention in this matter. Your prompt consideration to this appeal is appreciated.

Sincerely,

[Your Name]
[Your Address]

Enclosures:
1. Explanation of Benefits document dated **[date]** (if services were already received)
2. Doctor's Letter of Medical Necessity
3. Medical records
4. Documents explaining procedure