Sample Appeal Letter for Services Denied as "Not a Covered Benefit"

As someone with cancer or a caregiver for someone with cancer, you have a lot on your mind without having to worry about medical bills and insurance. But some insurance companies may reject claims for certain health services. You need to know that you have the option to appeal these denials.

When treatment is denied, you have the legal right to ask for an internal review. If this appeal is denied, you have the legal right to ask for an independent, external review. This right applies to health plans created after March 23, 2010.

For plans or policies purchased on or after July 1, 2011, the insurance company must tell you why your claim was denied. They must also tell you about your right to an internal appeal, your right to an external appeal if the internal review denies your claim, and the availability of a Consumer Assistance Program (CAP) if your state has one. State CAPs can help you work with your insurance plan to access benefits. To see if your state has a CAP, go to www.healthcare.gov/how-can-i-get-consumer-help-if-i-have-insurance.

Internal reviews must also be done within a certain time. For instance, a review for the denial of nonurgent care that you haven't gotten yet must be done within 30 days of your review request.

You can use the letter below as a model for an efficient, effective appeal letter. You may also need to get help from a legal professional. Make sure your healthcare provider knows any issues you have with insurance. Your provider may be able to help you.

The letter should be addressed to the name of the appeals analyst referenced in the denial letter. It should be sent certified mail, return receipt requested. If you're requesting an expedited review, it should also be faxed, Emailed, or hand-delivered.

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]

For more information on the Right to Appeal process, go to: www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/.