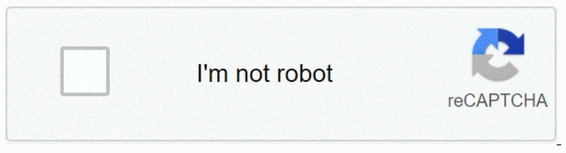

Continue

Medical claims appeal letter template

Here’s your guide to fighting back against denied healthcare claims Imagine you need to get an MRI. You’ve had unexplained headaches with no discernable trigger, and your provider wants additional tests to rule out anything serious. So, you get a referral from your healthcare provider, make an appointment, and then wait until the scheduled day.

Sample Physician Appeal Letter
Please note, this is NOT a form letter and should be customized for your patient's specific situation. You can use the suggestions in the brackets as a guide.

[Date]

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

Re: [Patient's Name]

[Patient's insurance member number]

[Group number/Policy number]
[Type of Coverage]

[Type of service denied and date of denial from EOB]
[Reason for denial from EOB]

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 it is believed that the procedure is [state specific reason for the denial found on the EOB, e.g., not medically necessary, experimental, etc.]

[Patient's name] has been under my care since [date] for the treatment of type 1 diabetes [T1D]. Since that time, [patient's name] has [include a brief overview of patient's treatments and T1D management protocol, e.g., the number of finger stick tests, insulin injections, or how frequently a pump is used. Include a brief medical history emphasizing the most recent events that directly influence your decision to recommend the denied therapy along with any peer-reviewed information, like this, that may support your request]. The service denied is critical in managing [patient's name]'s condition and access to this treatment will help improve [his/her] health outcomes by making it easier for [him/her] to manage and adhere to the recommended treatment plan.

For this reason I am writing to provide you with information regarding [name of denied procedure]. [Give a brief, yet specific description of the procedure and why you believe it should be approved and include a specific counter point to the reason noted in the denial on the EOB. Include potential downside of treatment not being covered like worsening A1C levels or additional out-of-pocket costs for more expensive alternatives. Find more helpful pointers in the chart in the "Denials and Appeals" resource].

Meanwhile, the radiologist’s office contacts your insurance to get the service approved. The day before your appointment, you get a call. Your insurance provider decided to deny the claim, which means you can’t have the scan. Or, worst-case scenario, you’ve already gotten it and your insurance denied the claim after the fact. Meaning, they won’t cover the cost. Your insurance company may have had the right to deny your claim, sure. But you have the right to know why they denied it. Legally, your insurance company must let you know exactly why your claim was denied or why they terminated your insurance coverage (if they did). They’re also required to tell you that you can appeal their decision. And you should, by writing a health insurance appeal letter. What is an insurance appeal letter? A letter of appeal to an insurance company is what you send to your insurance provider when they’ve denied a claim or ended your coverage. It’s your opportunity to disagree with whatever they’ve decided, and the company will then have to go through a review process to make sure everything was handled fairly and according to the law. You’re essentially asking them to reconsider their decision. This is something you can send, or your provider can appeal on a patient’s behalf as well. “If your health plan denies coverage for a treatment, test, service, or surgery, it is important to note that you do have the option to challenge this, which is called an appeal,” says Ben Aiken, MD, a family physician at Lantern Health and the VP of Health at insurance administrator Decent. “If your appeal is successful, then you may receive coverage for the service by the insurance company.” Here’s how to write an appeal letter to your insurance company. Before you send the letter There are two types of health insurance appeals — the first step is deciding which one is appropriate for your case. Internal appeal: This is when you appeal the denial directly with your insurance. They’re obligated to do a full review, but ultimately make the final decision on whether the service gets approved.

Health Insurance Appeal Letter

Mr. Terry H. Patty

Chief Executive Officer- Health Insurance Department

Met Life Health Insurance Company Pvt. Ltd

4277 Crow-field Road

Gilbert, AZ 85233

02 September, 2010.

Dear, Mr. Patty

I am Mrs. Amy C. Hinton making an appeal with your health insurance company. I have got admitted to Bridge Candy Hospital in New York because I am suffering from Heart Attack I have got a serious attack and due to which I had to undergo for a heart transplant surgery which is to be done at the earliest after the operation I cannot move myself therefore I am writing this letter to you in advance. The entire cost of surgery is approximately around $50000 which includes hospital bill and medicine expenses. I have taken a special health care insurance policy from your insurance company for which my policy number is HI-875021.

I am ready to help you with regards to all necessary documents needed by you. Please prefer my case in a very special manner because the amount has to be paid to the hospital authority before my discharge which is on 15th October, 2010.

Yours Sincerely,

Mrs. Amy C. Hinton

1224 Lynn Street

Cambridge, MA 02141

External appeal: This is when you send the appeal out to a third party for review.

Sample Claims Appeal Letter
[To be printed on Physician's Letterhead]
[Date]
[Insurer Name]
[Attn:]
[Address]
[City, State, Zip]

Re: [Patient Name]
[Policy Number]

Dear [Insurer] :

This correspondence serves as a request for reconsideration of coverage and payment for [Name of Patient] for the administration of Supprelin LA for the treatment of Central Precocious Puberty. Supprelin LA is an implant that is inserted subcutaneously in the inner aspect of the upper arm and releases a controlled dose of approximately 65 mcg per day of histrelin acetate, a gonadotropin releasing hormone (GnRH), continuously over a twelve-month period of time. Continuous administration of histrelin results in decreased levels of luteinizing hormone (LH) and follicle stimulation hormone (FSH).

You have indicated that Supprelin LA is not covered by (Name of Health Insurance Company) because of (insert reason).

Central precocious puberty (CPP) is an important and increasingly recognized condition that can have a profound physical as well psychological impact on children and their families. Central precocious puberty is characterized by the premature development of secondary sexual characteristics due to an increase in secretion of the sex hormones. If left untreated, the disorder may limit a child from attaining full adult height, resulting in short stature. The condition occurs in one in every 5,000 to 10,000 children with females being affected more commonly than males. Supprelin LA is a significant advancement in the treatment of CPP, providing a rapid and sustained suppression of hormone levels for a full year. Supprelin LA reduces the need for frequent dosing and improves long-term compliance. Supprelin LA was approved for marketing by the Food and Drug Administration (FDA) on May 4,2007.

In clinical trials, treatment with Supprelin LA resulted in hormonal suppression, the absence of clinical progression of puberty and menstrual bleeding, a significant decrease in bone-age advancement, a decrease in growth velocity and a decrease in LH and FSH levels for 12 months in all measured study participants.

I would appreciate your reconsideration of coverage for Supprelin LA for this patient. If you have any further questions, please feel free to call me at (insert your telephone number, including area code) to discuss this appeal.

Thank you in advance for your immediate attention to this request.

Sincerely,
[Physician Name]

In this situation, the third party makes the final decision, and the insurance company must comply. This is often done after an internal appeal has been denied. Writing a strong appeal letter Once you’re ready to appeal, write a letter including all the necessary information for an appropriate review of your claim. Noor Ali, MD, founder at Dr. Noor Healthcare Advisor, says that it also includes “strong supportive documents, [like] medical evidence, clinical notes, professional statements,” and more. The National Association of Insurance Commissioners suggests using the following as a good template for the letter. 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.

To,

Larry King

Claims Manager

Lombard General Insuance

23 Time Line Road,

West Minster, United Kingdom 5678

Dated: 10° of February 20XX
Subject: Appeal for the claim made.

Respected Mr. King,

This letter is to inform you that I had made claim for the compensation for the damages of my car. I hold car insurance under your company with policy number CI 789.

I had written a claim letter on 10° of January 20XX, but there has been no response till now. Usually it takes around two weeks to get the compensation for the amount but it's been a month and even an investigation officer has not yet come to look into the matter.
I would request you to look into the matter. I am going through a terrible financial crisis and urgently in need of the compensation amount. I am also enclosing the repairing bills of my car along a photo copy of my policy.

I had written a claim letter on 10° of January 20XX, but there has been no response till now. Usually it takes around two weeks to get the compensation for the amount but it's been a month and even an investigation officer has not yet come to look into the matter.
I would request you to look into the matter. I am going through a terrible financial crisis and urgently in need of the compensation amount. I am also enclosing the repairing bills of my car along a photo copy of my policy.

Regards,

Nathan Lee.

John Mayo.

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 "When you respond, pay close attention to the reason for the denial, and make sure to address it in your appeal letter," Dr. Aiken says. "Getting your provider involved can be an effective way to improve your chances of having a claim denial overturned." Your provider can provide a secondary letter as supplemental documentation to your letter—or they may be handling the appeal's process entirely. Sending the letter Just like everything else with health plans, Dr. Aiken says, yours likely has its own instructions on how to appeal a denial. Be sure you've checked exactly who to send it to and how (via regular mail or electronically) and what specific documentation your insurance company might require to be included. Dr. Ali says the letter should typically be addressed to "the claims department or claims adjuster, or a specific department for appeals" at the insurance company. That information can be determined by looking at your plan information, finding the appeals page on your insurance company's website, or calling the company to ask. Insurance appeal letters need to be Health Insurance Portability and Accountability Act (HIPAA) compliant, which means you can generally only send them in ways that prevent fraud, Dr. Ali says. So, expect to physically mail your letter or fax it—but remember to first determine which method your insurance provider prefers. After you send the letter Once you've sent your letter (and written down the date you sent it), it's time to hurry up and wait. The letter will need to be received, logged, and processed, which typically takes about 30 days, Dr. Ali says. Some companies take longer, though. Follow up after 30 days, unless your insurance provider has given you different guidance. What to do if your appeal is rejected If the response to your appeal leads to covered services, congratulations! You're done. But if your appeal is rejected, then you have a few options. You can accept it and work with your provider to negotiate a self-pay price. You can pay the cost out of pocket, without negotiating a self-pay price. You can wait until open enrollment, and then pick a new plan that better provides for your medical needs for the following year. You can appeal the new decision. "Generally, there are several levels to an appeal process," Dr. Aiken says. "It means that if you are denied after the first appeal, you can appeal again.
If denied after your first appeal, review the reasons for the second denial and include more documentation supporting your reasons for needing the care or treatment. After two or more denials, you can ask for an independent review, which means a clinician in the applicable specialty will be assigned to review the case." Ultimately, it comes down to exactly why your insurance rejected a service. According to data from the Centers for Medicare and Medicaid Services, those with Affordable Care Act plans in 2020 had denied claims for two main stated reasons: the service was excluded from their plan coverage, or preauthorization wasn't provided for service. Dr. Aiken says that for excluded services, you'll have an uphill battle trying to get the service approved. But for situations where there was a lack of prior authorization or no referral, you can get your healthcare provider involved and they can typically get the denial reversed. RELATED: What does Medicare cover? Always remember: It's your right to appeal a denial, and you should take the chance to do it. Creating a medical appeal letter is still confusing to many healthcare providers. Sometimes, even the seasoned healthcare provider doesn't do the best job writing the appeal letter. Here are some handy tricks to create an effective appeal letter to medical insurance providers. Tip 1: Use A Hospital Appeal Letter Sample To Save Time Many patients and healthcare organizations often overlook the time perspective of medical claim denials. Doctors already have a busy life, and most of them still wish they could get more time with their patients. Hence, you can imagine how little time they have for the Patient's insurance appeal letter. Furthermore, the healthcare industry has one of the highest burnout rates for working professionals. The main takeaway is that healthcare professionals and organizations rarely have enough time to send several appeal letters. Even if healthcare organizations could magically create more time out of thin air, they would use it for their patients. So, what is the silver lining we are trying to make here? Using a tried and tested hospital appeal letter sample and an automated direct mail system can help you speed up the process significantly. Use The Data From Medical Claim Denial Letter Whenever you receive a medical claim denial letter, you can get some basic information for your appeal letter from it. For example, the claim denial letter contains essential details like Identity of the insurance provider Claim Adjustment Reason Code (CARC) Date of claim denial Although these details may not sound like much, it is good enough for your healthcare organization as it usually has the other information. So, all you have to do is put the two together and create a comprehensive insurance appeal letter. Tip 2: Incorporate Your Branding And Enhance Professionalism When it comes to the healthcare industry, the branding aspect usually takes a back seat, which is not an ideal practice. Again, it is perfectly understandable that healthcare providers focus all their efforts on serving their patients. However, that does not mean you have to ignore branding altogether. Your medical appeal letter is a great way to give precedence or, at least, more significance to your branding. Often, the doctor's name and title alone on a mailer are enough for anyone to understand its essential nature. However, with appeal letters, every one of them is from a doctor's office, and it loses its charm. Use Branding To Capture The Reader's Attention Make your appeal letters stand out by incorporating your brand's design aspects. You can use these design elements throughout your mailer. Whether you want to take a subtle approach or a more rudimentary one is entirely up to you. A basic guideline for incorporating your branding into the insurance appeal letter is using your organization's logo and color pallets. Finally, never make the mistake of thinking that the design and formatting of your appeal letter do not make a difference. Tip 3: Safely Store Your Records and Tracking Information Another thing to note when sending an appeal letter for your healthcare organization is always to maintain accurate records. The record should include A copy of your appeal letter Time and Date of when you sent it Time and Date of the insurance company receiving your letter Among the points listed above, the last one is critical. You must have the tracking information of your letter regardless of whether you send it online or offline. It is relatively easy to track your medical appeal letter with online channels. But if you want to track offline letters, we suggest that you use an advanced print and mail automation tool like PostGrid. It enables you to better track all your direct mail, including your appeal letters, and gain valuable insights. Consider Additional Time Required For Follow-Ups Insurance companies are known for their quick replies. They do not respond immediately to your insurance appeal letter, and you can almost always expect some delays. With advanced tracking, you get a glimpse into how complex the process is. More importantly, you get an idea of the time required to get a reply from the insurance provider. Keeping accurate records of your appeal letters enables you to send follow-up letters just at the right time. As a result, you can minimize the time required to get a response from different insurance providers. Tip 4: Use An Automated Print and Mail System As we have already mentioned, one of the biggest challenges healthcare providers face when sending appeal letters is the lack of time. Automation is the ultimate solution to save a significant amount of time regardless of when or where you employ it. You can use an advanced print and mail solution like PostGrid for printing personalized medical appeal letters. Furthermore, you can also use letter templates to speed up the process. PostGrid also comes with HIPAA certification, which means it can securely use your patient data without any risks. You also get advanced tracking and insights from PostGrid, which ultimately helps you optimize your direct mail communication. Hence, you can ensure that your appeal letters and other documents such as follow-up mail, patient statements, and more are always on time.