What To Do When Insurance Denies Coverage: The Appeal Process

This guide will provide some basic information about your rights regarding health insurance.

If you or someone you know has questions about how health insurance works for mental health or substance use disorder call the free CHAMP helpline at 888-614-5400

What Is an Appeal?

An appeal is the formal way to challenge a decision made by your health insurance plan when they deny covering treatment or medication.

All insurance plans have an appeal process, and it is your right to use it. The process may be different depending on the type of insurance you have but it should be included in your insurance policy handbook.

It can be confusing and a lot to navigate on your own, but CHAMP is here to help.

What Does a Denial Look Like?

A denial from your insurer may be verbal or written.

Verbal denials may come from a representative who explains on the phone that the services you are asking about will not be covered. It could also come from them informing you a request from your doctor has been denied. If a denial is over the phone, you should ask your insurer to give it to you in writing.

Written denials may come in an explanation of benefits (EOB) or a formal denial letter. EOBs will list the services your plan will cover and how much they will pay. If a treatment or medication is not covered in your EOB it may be considered a notice of a denial. Formal denial letters will more clearly state that a requested service is being denied and provide you with instructions on how you may challenge the decision.

Do Appeals Really Work?

Yes! Every case is different, but studies have found that those who do appeal have a good chance of at least partially changing their insurer's decision.

Talk to Your Doctor First!

Before going through the process of filing an appeal, you may want to call your doctor and see if they can speak with the insurance plan.

The doctor that prescribed the treatment has the right to a "peer-to-peer" conversation with the plan to find out why the treatment was denied.

Where Do I File an Appeal?

The denial letter you received from your health insurance plan should state where your appeal paperwork needs to be sent. If it does not or you have misplaced your denial notice reach out to your health insurer and ask.

What Do I Include in an Appeal?

Complete all the forms provided by your health insurer. These forms will usually require:

1. Your name
2. Claim number
3. Health insurance ID number
4. Your reason for appealing.

You can also submit any additional information that you want the insurer to consider, such as a letter from the doctor. A letter from your doctor can be important in helping the insurance company understand why the treatment that was requested is needed.

Some types of appeals *require* you to include specific items with your appeal.

For example, if you are appealing a denial of a request to see an out-of-network provider, your appeal must include a letter from a physician to get external appeal rights; if you don't include the letter, you won't have the right to an external appeal if you need one.

Keep your original documents and submit copies to your insurance company.

CHAMP helps people with their appeals for free. Call our Helpline to speak with someone about your case.

Timeline of an Appeal

Receive a Denial

You will usually have **180 days** from the day you receive a denial to file an appeal with your health insurer. However, it is a good idea to double check if the deadline of your specific plan is different. **It is very important file your appeal before the deadline!**

File an Internal Appeal

Most insurance plans allow appeals to be filed over the phone or in writing. Your denial letter or Explanation of Benefits should explain how to file an appeal and how long you have to file it. It is very important to file appeals before the deadline!

Most insurers must decide on your appeal within:

- **72 hours** or less in urgent care cases.
- **30 days** for prior authorization requests.
- **60 days** for medical services already received.

For people who are receiving inpatient substance use disorder treatment some plans may have even faster timelines called expedited appeals.

File a Second Internal Appeal

This step is not always an option or required. However, for some it is necessary before filing an external appeal.

Read your insurance policy carefully. If you are not sure call the CHAMP helpline and we can help you figure out the steps you need to take.

File an External Appeal

If your internal appeal is also denied by your insurer, you may be able to file an external appeal. External appeals are reviewed by someone outside of the health insurance company, but they can only be filed for certain types of cases.

For most plans, denials involving medical judgment are eligible for external appeal. This can include denials based on medical necessity, experimental or investigational treatments, and out-of-network referrals.

Most insurance plans allow **4 months** to file an external appeal after receiving your first internal appeal decision.

It is important to know that if your health care provider filed the appeal for you, most plans require that the provider be the one to also file the external appeal. This must usually be done within **60 days** of the internal appeal decision. Your denial should provide information on how and when to file an external appeal. CHAMP can also help you understand your external appeal rights.

A decision about your external appeal should be made within **30 days**. If it was an expedited appeal a decision should be made within **72 hours.**

Not Sure what type of insurance you have?

Need help writing the appeal?

CHAMP can help you with both, just give us a call.

What to Do After Filing an Appeal?

Keep copies of all information related to your claims and denials. Make sure you keep *all* the pages. This includes information your insurance company provides to you and information you provide to your insurance company like:

1. The Explanation of Benefits forms or letters showing what payment or services were denied or only partially covered
2. A copy of the request for an internal appeal that you sent to your insurance company and any acknowledgement from the insurer that they received the appeal
3. Any documents with additional information you sent to the insurance company (like a letter or other information from your doctor)
4. A copy of any letter or form you're required to sign, if you choose to have your doctor or anyone else file an appeal for you.
5. Notes and dates from any phone conversations you have with your insurance company or your doctor that relate to your appeal. Include the day, time, name, and title of the person you talked to and details about the conversation. When speaking to a plan representative by phone, ask for a call reference number and write it down in your records.

Mark the deadline for the insurance company's response to your appeal on your calendar. It is also a good idea to call your insurer a few days after you submit the appeal and confirm they have your appeal and are reviewing it.

Notes: