Sample Appeal Letter A
Request for Specialty Specific Clinical Review Criteria
Available at AppealLettersOnline.com and AppealTraining.com

[~Current Date~]

Attn: Appeals
[~Insurance Policy #1 Carrier~]
[~Insurance Policy #1 Address~]

Re: Patient: [~Patient Name~]
Policy: [~Insurance Policy #1 Number~]
Insured: [~Responsible Party Name~]
Treatment Date: [~Treatment Date~]
Amount: [~Amount~]

Dear Appeals,

It is our understanding that this treatment was denied pursuant to medical necessity or other specialty care policy or plan coverage limitations. The explanation of benefits did not give adequate information to establish the accuracy of this decision. Therefore, please provide the following information to support this adverse determination.

Please furnish the (SPECIALTY) clinical review criteria used to reach this decision. This information is necessary to determine if the clinical rationale used in making the coverage decision is consistent with current (SPECIALTY) standards of care developed by practicing specialists in this field of medicine.

It is our position that this treatment is medically necessary and appropriate for this patient's medical condition. Further, any medical guideline employed in any aspect of medical decision making must be flexible and allow for deviations from the guideline in order to accommodate the patient's unique medical needs and challenges. Therefore, we request the following information which will allow us to assess the appropriate application of the clinical guideline and determine if the referenced guideline is specific to this patient's needs:

- Name of the board certified (specialty) reviewer who reviewed this claim and a description of any applicable advanced training or experience this reviewer has related to this type of care;
- Board certified (specialty) reviewer's recommendation regarding alternative care;
- A copy of applicable internal clinical guideline, source of the guideline and the date of development;
- An outline of the specific records reviewed and a description of any records which would be necessary in order to justify coverage of this treatment;
- Copies of any peer-reviewed literature, technical assessments or expert medical opinions reviewed by your company in regard to treatment of this nature and its efficacy;

It is our position that failure to provide the requested information may violate state and/or federal claim processing disclosure laws or, in the minimum, non disclosure reflects a poor quality medical process which discourages treatment provider input. Disclosure standards are meant to ensure that all qualified parties have access to the information necessary to properly appeal an adverse determination. Therefore, we appreciate your prompt, detailed response to this request.

Closing Text,

Additional Customization Suggestions:

Summarize Patient's Condition and Care And Attach Medical Records

Cite Internal Clinical Criteria used to develop Treatment Plan

Negotiate and Cite Managed Care Medical Necessity Review Requirements which specify which clinical criteria to utilize in decision making

Sample Appeal Letter B
US Mental Parity (MHPAEA) Appeals – UCR
Available at AppealLettersOnline.com and AppealTraining.com

[~Current Date~]

Attn: Director of Claims
[~Insurance Policy #1 Carrier~]
[~Insurance Policy #1 Address~]

Re: Patient: [~Patient Name~]
Policy: [~Insurance Policy #1 Number~]
Insured: [~Responsible Party Name~]
Treatment Date: [~Treatment Date~]
Amount: [~Amount~]

Dear Appeals,

The above referenced claim was denied and/or reduced due to a usual, customary and reasonable adjustment to the benefits for mental nervous/substance abuse treatment. This letter is to request immediate reconsideration of this denial.

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that certain plans cover mental health services – including inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs – on a parity basis with medical/surgical services. Please provide the following information in order to facilitate our review of your decision for MHPAEA compliance:

- The Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;The specific plan language regarding the imposition of the NQTL (such as a how usual, customary and reasonable calculations are made);
- The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;
- Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;
- The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and
- Any analyses performed by the plan as to how the NQTL complies with MHPAEA.

It is our position that these charges are within usual, customary and reasonable charge amounts for this type of care in the region. Please reprocess this claim allowing full benefits for the treatment. If no additional benefits are released, we appreciate your written response to this appeal with supporting documentation as specified above and/or a description of any records which might be necessary in order for additional benefits to be allowed.

Closing Text,

Additional Customization Suggestions:

Attach Pricing Information
Cite Treating Physician's Board Certification and/or specialty training

Sample Appeal Letter C
Request for Prompt Appeal Decision – URAC Requirements
Available at AppealLettersOnline.com and AppealTraining.com

[~Current Date~]

Attn: Appeals
[~Insurance Policy #1 Carrier~]
[~Insurance Policy #1 Address~]

Re: Patient: [~Patient Name~]
Policy: [~Insurance Policy #1 Number~]
Insured: [~Responsible Party Name~]
Treatment Date: [~Treatment Date~]
Amount: [~Amount~]

Dear Appeals,

Our office recently filed an appeal related to the above referenced claim. However, no response was received from your company. It is our position that this failure to promptly respond to the appeal is a violation of the Utilization Review Accreditation Commission (URAC) Claim Processing Standards.

As you are likely aware, URAC claim processing standards require organizations seeking to maintain claim processing accreditation to establish a claims appeals process and process appeals within 60 calendar days. Further, a health professional must be involved in any adverse determination that involves clinical judgment.

Please accept this written request for an immediate appeal response. We also request the name and credentials of the health professional involved with the review as well as a copy of any policy language, clinical criteria or other resource used in the review and specific instructions for initiating the next level of appeal.

Closing Text,

Additional Customization Suggestions:

Cite State-specific and/or contract appeal review terms