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TRIAGE HEALTH

State-Specific Health Insurance Appeals Toolkit







A step-by-step guide to appealing health insurance denials in your state

Triage Health State-Specific Appeals Toolkit

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Overview of Health Insurance Appeals

Understand the Basics

What is a Health Insurance Appeal?

At some point, while receiving medical care, you may experience a denial of coverage from a health insurer, whether for an imaging scan, prescription drug, treatment, procedure, or test. This is sometimes called an "adverse benefit determination." Many people assume that their health insurer has made the correct decision. So, they accept the denial of coverage and either do not get the medical care prescribed by their health care team, or try to find a way to pay for it themselves. However, if a health insurer denies coverage for your medical care, you may have a right to appeal the decision. In cases where individuals file an appeal, they can win: According to Kaiser Family Foundation analysis of 2023 Marketplace plan data, patients won 44% of appealed denials. When appeals go on to external review, data shows that patients win between 39-59% of the time, across different states. Yet 99.9% of denied claims are never appealed.

This toolkit is designed to help you:

(1) identify the type of health insurance plan you have;
(2) figure out how to file a health insurance appeal based on your type of health insurance and where you live; and
(3) understand steps to take if your appeal is denied.

This toolkit covers appeals of decisions made by your health insurer. If you want to appeal a decision made by the Health Insurance Marketplace (e.g., about your eligibility for coverage or financial help), that is a separate process. Visit HealthCare.gov/marketplace-appeals for more information.

This toolkit can also be useful for health care teams and advocates who are supporting patients and caregivers.

Health care providers often file appeals on behalf of their patients, especially when a pre-authorization is denied. However, it is important not to assume that they will. Talk with your health care team about whether they will be filing the appeal.

Note: the most up-to-date information about appeals and navigating health insurance can be found at TriageCancer.org/HealthInsurance.

Key Terms to Understand

There are a number of terms used in health insurance that are helpful to understand.

- **Health Insurer**: in this toolkit, we use "health insurer" to refer to the company or plan that makes coverage decisions under your health insurance. Usually, this is an insurance company. If you have a self-funded employer plan, this is your employer's plan, even if an insurance company administers it (e.g., pays claims, mails out EOBs).
- **Policyholder**: the person who owns the health insurance policy (e.g., the employee who signs up for an employer plan). Other people covered under the policy, such as a spouse or children, are usually called dependents. Your plan documents may also use the terms "subscriber," "member," or "participant."

- **Adverse Benefit Determination (ABD)**: When a health insurer decides to deny, limit, or end a benefit or coverage.
- **Internal Appeal**: an appeal that goes directly to the health insurer that has denied coverage. This is typically the first step in the appeals process.
- **External Appeal**: an appeal that goes to an independent third party rather than the health insurer.
- **Pre-authorization**: approval from a health insurer before a patient receives care; also known as prior authorization, pre-approval, or pre-certification
- **Medically Necessary**: health care services that are needed to diagnose or treat a medical condition. See *What Does Medically Necessary Mean?* below for more information.
- **Experimental or Investigational**: a term health insurers use for treatments they consider unproven (e.g., a treatment that has not been approved for that condition). Each health insurer defines this term in its plan documents, so check how your plan defines it.
- **In-network Provider**: a health care provider or facility (e.g., hospital, pharmacy) that has contracted with your health insurer. The provider or facility agrees to be paid certain amounts by the health insurer (i.e., the allowed amount).
- **Out-of-network Provider**: a health care provider or facility that may still accept your health insurance, but does not have a contract with your health insurer so there are no agreed-upon prices for medical services.



- **Appeal:** A formal request to your health insurer, or an independent reviewer, to reconsider a coverage decision. Appeals can be filed before you receive care (i.e., when a pre-authorization is denied). Appeals can also be filed after you receive care. They are one of the most important tools available to you when coverage is denied.
- **Grievance:** A grievance is a formal complaint submitted directly to your health insurer about the quality of care or service you received. For example, you might file a grievance if you experienced a long delay in getting an appointment with an in-network provider, or if you felt you were treated poorly by a member of your health insurer's staff. A grievance is different from an appeal. An appeal challenges a coverage or payment decision, while a grievance addresses how you were treated or the quality of care you received. Some plans use the terms interchangeably, so if you are unsure if you should file an appeal or a grievance, contact your health insurer and ask which process to use.
- **Regulatory Complaint:** a report filed with a government agency, such as your state's Department of Insurance, or the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for ERISA plans, about whether your health insurer or employer is complying with the law. This is different from an appeal, which challenges a specific coverage decision, and different from a grievance, which is a complaint to your health insurer about the quality of care or service you received. A regulatory complaint can prompt government oversight or enforcement, but filing one is not a substitute for filing an appeal if you want a specific denied claim reconsidered.
- **Funded Plan**: an employer-sponsored plan where the employer buys a health insurance policy from an insurance company, and the insurance company pays employees' medical claims. These plans are also called "fully insured" or "insured" plans. Most state insurance laws apply to funded plans.
- **Self-insured (or Self-funded) Plan**: the employer pays for employees' medical claims directly, instead of buying a policy from an insurance company. A third-party administrator (TPA) may administer benefits, process claims, and manage the prescription drug benefit for the employer.
- **Short-term Plan**: a health insurance policy that you buy directly from an insurance company that lasts less than a full year. Short-term plans are not required to follow many of the consumer protections in the ACA, including the appeals rules discussed in this toolkit, and they may refuse to cover pre-existing conditions.

What Does Medically Necessary Mean?



Medical necessity is a term that health insurers use to decide whether they will pay for a health care service. Many denials are based on a health insurer's decision that care is not medically necessary, so it's helpful to understand what this term means. You can typically find your plan's definition in its plan documents (e.g., your policy, Evidence of Coverage, or Summary Plan Description). Generally, a service is considered medically necessary if:

- it is needed to diagnose or to treat your health condition or its symptoms;
- it follows the standards of care that health care providers generally accept; and
- it is not mainly for convenience, whether yours, your family's, or your provider's.

Some plans also look at cost, whether a different service would work just as well, and where you get the care (e.g., a hospital or an outpatient clinic).

Even if your health insurer decides that your care is not medically necessary, you can challenge that decision through an appeal. Some states have laws that define medical necessity, either for all health care or for specific types of care, such as mental health and substance use disorder treatment. If your state has one, Part II will explain the definition and which plans it applies to.

When Can You File an Appeal?

You can file appeals both before and after you receive medical care. For example, you might get a denial of coverage before you even receive care if your health insurer requires a pre-authorization for the service. If the pre-authorization is denied, you can appeal that decision.

Getting a Pre-Authorization

Health insurers may require you to get their written approval before you receive certain medical care, including specific treatments, medical devices, and prescriptions. This approval is called pre-authorization, but might also be called pre-auth, prior authorization, prior auth, prior approval, pre-certification, treatment authorization request, or advanced approval. Health insurers are not required to pay for medical care that requires pre-authorization, if a patient receives these services without the pre-authorization. Patients may then have to pay the full cost of the medical care.

Most health insurers do not provide a list with the medical care that requires a pre-authorization, so you may have to ask. Your health insurer may also change its pre-authorization requirements at any time. Sometimes, your health care team will request a pre-authorization for you. But if they don't, and you get the medical care without the pre-authorization, then your health insurer may refuse to pay for the care. This means that it is always helpful to ask your health care team if they will be getting any necessary pre-authorizations for you.

These are some key steps to getting pre-authorization:

- Ask your health insurer if the care you need requires pre-authorization and the process to get it.
- Ask your health care team if they will get the pre-authorization from your health insurer, or if you will have to do that.
- Complete and submit your forms on time. Many health insurers have deadlines. Start the pre-authorization process as soon as possible to make sure your medical care is not delayed.

- Always keep a copy of your pre-authorization request in case the request is lost.

Under federal rules, your health insurer generally must decide a pre-authorization request within 15 calendar days, or within 72 hours if your request is urgent. In some cases, your health insurer may take up to 15 more days for a non-urgent request if it needs more information or for reasons beyond its control.[1] Many states have laws that require health insurers to make these decisions faster. Check Part II for information about your state.

Also, even if your pre-authorization is approved, it does not guarantee that your health insurer will cover your care.

When Filing an Appeal May Be Useful

Filing an appeal may be useful in these common situations:

- **Pre-authorization Denial:** If your pre-authorization is denied, you can appeal that decision. Because a delay may affect your treatment, talk with your health care team about whether to request an expedited (urgent) appeal. If you do not get a required pre-authorization before getting care, you can ask your health insurer to retroactively authorize it.
- **Not Medically Necessary:** Health insurers sometimes deny coverage by claiming that a treatment, test, or service is not medically necessary. Your health care team can provide documentation and support to explain the care is medically necessary.
- **Experimental or Investigational Treatment:** A denial based on a treatment being labeled "experimental" or "investigational" can often be challenged, especially if there is clinical evidence or medical guidelines supporting the care. Your health care team can help you gather that evidence.
- **Step Therapy (Fail-First) Requirements:** Some health insurers require you to try a less expensive medication, show that it is not working or that you had an adverse reaction (e.g., an allergic reaction), before they will cover the treatment your health care provider has prescribed. If your provider believes the required first-step treatment is not appropriate for you, you may be able to appeal for an exception.
- **Formulary Exception:** If a medication your provider has prescribed is not on your health insurance plan's list of covered drugs (also called a formulary), you may be able to request an exception based on medical necessity. Common types of exceptions include: a non-formulary drug exception (asking the health insurer to cover a drug that isn't on the formulary); a tier exception (asking it to treat a drug as if it were in a lower cost tier); and a brand exception (asking it to cover a higher-cost brand-name drug even though a generic is available). For most individual and small group plans, once an exception request is received, the health insurer generally must decide within 72 hours for standard requests and 24 hours for urgent requests.[2] Note: other plans, including many large employer and self-funded plans, may have different timelines, so it is important to check your plan documents.
- **Network Exception:** Sometimes, your health insurer's network may not include a provider with the specialized expertise needed for your medical condition. When an appropriate in-network provider is not available, you may be able to request a network exception, sometimes called a gap exception, to receive care from an out-of-network provider at in-network cost-sharing rates. Your health care provider can help by documenting why in-network options are insufficient for your care needs.
- **Coverage Criteria Exclusion:** Health insurers sometimes deny coverage for a service based on standard eligibility criteria, such as age or gender. But, your individual health situation may make that service medically necessary. For example, a colonoscopy may be denied because you are younger than the standard screening age, but you may have a family history of colorectal cancer. Or, a

[1] 29 CFR § 2560.503-1(f)(2)(i) and (f)(2)(iii)(A).
[2] 45 CFR § 156.122(c).

mammogram may be denied for a man, but he carries a BRCA mutation. In these situations, your health care provider can document why the standard criteria do not apply to you. And, you can appeal the denial on the basis of medical necessity.

- **Service Not Covered or Excluded:** If your health insurer denies coverage, claiming that a service is not covered or is excluded, review your plan documents carefully. If the service is not explicitly listed as excluded, you may have grounds to appeal.
- **Denial of Breast Reconstruction**: The Women's Health and Cancer Rights Act (WHCRA) requires most individual and employer-sponsored health insurance plans that cover mastectomies to also cover all stages of breast reconstruction, including surgery on the other breast to achieve symmetry. It also covers treatment of physical complications at any stage of the mastectomy, including lymphedema. If your health insurer denies a reconstruction-related claim, you can cite WHCRA directly in your appeal. Note: WHCRA does not apply to Medicare or Medicaid.
- **Denial of Routine Costs While Participating in a Clinical Trial**: If you are enrolled in an approved clinical trial, the Patient Protection and Affordable Care Act (ACA) generally requires most private health insurers to cover the routine costs of care associated with the trial, such as office visits, lab work, and imaging. It does not have to cover the experimental care being studied. This requirement does not apply to grandfathered plans, and self-funded plans are not required to follow it, though many do. If your health insurer denies routine care costs during a clinical trial, you may be able to appeal.
- **Billing or Coding Errors:** Errors can occur relating to patient identifying information, billing details, or CPT/HCPCS codes. Review your bills carefully, and don't be afraid to ask your provider for help. Ask your provider to resubmit the claim with corrected information. Denials caused by errors can often be resolved with a phone call before a formal appeal is necessary. A provider can fix the claim and resend it to the health insurer.
- **Timely Submission:** Claims submitted by providers too long after services were provided may be denied. If your provider is in-network, fixing this error usually only requires a phone call, as in-network providers are typically responsible for submitting claims on time to the health insurer.



- **Coordination of Benefits (COB):** If you have two health insurance plans, it is important to complete and submit COB forms every year. These forms clarify which plan is supposed to pay a claim first and which one pays second. Failing to complete the COB form can result in claim denials.
- **Rescission of Coverage:** If your health insurer retroactively cancels your plan, you have the right to appeal that decision. The ACA prohibits rescission except in narrow circumstances, such as non-payment of premiums or intentional fraud.
- **Alternative Funding Programs (AFPs):** If your plan uses an AFP that denies coverage for a medication, you may have the right to appeal the initial denial through the internal and external appeals process. For more information, see our Quick Guide to Co-pay Accumulators and Maximizers, & Alternative Funding Programs (TriageCancer.org/QuickGuide-CoPayAccumulators).
- **Co-pay Accumulators:** As of 2026, more than 25 states have passed laws banning or limiting co-pay accumulator programs. If you live in one of these states, and have an individual or insured employer-sponsored plan, you may have the right to file an appeal. If you have a self-insured employer plan, federal rules apply and currently allow accumulator and maximizer programs, except when the medication has no available generic equivalent. For more information, see our Quick Guide to Co-pay Accumulators and Maximizers, & Alternative Funding Programs (TriageCancer.org/QuickGuide-CoPayAccumulators).

Surprise Medical Bills

Even if your claim is not denied, you may still receive an unexpected bill. You might face a surprise medical bill

when you receive care from a provider you did not know was out-of-network. For example, you schedule a surgery with a surgeon and hospital that are in-network, but after your surgery, you find out that the anesthesiologist was not in-network when you get a large surprise bill from the anesthesiologist.

The federal No Surprises Act (NSA) protects people who have individual or employer-sponsored health insurance from many surprise medical bills by:

- requiring private health insurance plans to cover out-of-network surprise medical bills; and
- prohibiting health care providers from billing patients more than their in-network cost-sharing amount for those services.



Under the law, out-of-network providers must send bills directly to your health insurer. The health insurer treats the providers as if they are in-network. After getting paid by your health insurer, the provider may only bill you for your regular in-network co-payment, co-insurance, or deductible amount.

The NSA applies to both emergency and certain non-emergency medical services. Emergency services include care provided in an emergency room and services related to active labor. The law also applies to emergency air ambulance services. However, it does not apply to ground ambulance services. Non-emergency services include many services provided by out-of-network providers at an in-network facility, such as anesthesia, radiology, and lab work.

The NSA does not apply to people covered by Medicare or Medicaid, as those programs already include similar protections.

If a bill is not properly identified as a surprise medical bill under the NSA, you may need to take action. You can start by contacting your health insurer or the health care provider to request that the bill be reviewed and processed correctly. In some cases, this may resolve the issue. If the issue is not resolved, you can contact the No Surprises Help Desk for assistance. The Help Desk is run by the U.S. Department of Health & Human Services (HHS), and can review surprise medical bills that are new, unpaid, or already in collections.

To contact the Help Desk:

- **Phone:** Call 1-800-985-3059
- **Online:** Submit a complaint at CMS.gov/NoSurprises

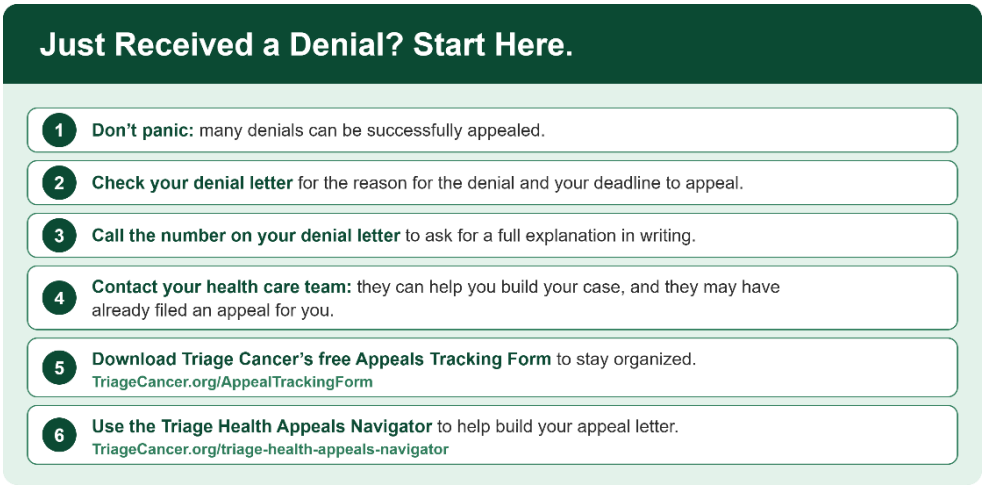
If you are unsure whether your bill qualifies as a surprise bill under federal law, contact the help desk. They can help you determine whether the NSA applies to your situation and walk you through next steps.

If your health insurer denies a claim, or charges you more than your in-network cost-sharing for a service protected by the NSA, you can also file an appeal. That decision may be eligible for an external appeal.
If you signed a form giving up your No Surprises Act protections, you may still be able to appeal, and request an external appeal, if you were not in a condition to understand the form or give informed consent (e.g., you were in severe pain or had been given medication before a procedure).

Note: state laws may be more protective than the federal NSA. Visit our Chart of State Laws: No Surprises Act to learn about the laws in your state at TriageCancer.org/State-Laws/Health-Insurance-No-Surprises-Act.

What to Do When a Claim is Denied

Regardless of the type of health insurance coverage you have, it is important to take these steps after getting a denial:



1. **Ask for a detailed explanation of your denial.** Your health insurer is required to provide the specific reason for the denial and the plan provision it relied on. Understanding the reason for the denial will help you build your appeal. If you are unsure about any part of the denial, contact your health insurer and ask for clarification in writing. Your denial letter should include information about why the claim was denied and describe any guidelines or criteria your health insurer used to make its decision.[3] If your claim was denied as not medically necessary or experimental, your health insurer must explain the clinical reasons for its decision or tell you that you can get that explanation for free. You can also ask for a free copy of the guidelines or criteria it used, and for the diagnosis and treatment codes on your claim and what they mean. Your denial letter should also tell you if there is a Consumer Assistance Program or ombudsman in your state that can help you. **Request language assistance if you need it.** If English is not your primary language, you may have the right to request notices, documents, and other communications in your preferred language for free. You can also request interpreter services when communicating with your health insurer. Contact your health insurer directly to make this request.
2. **Keep track of all communications.** Record the dates of any contact with the health insurer's staff, the names and titles of individuals you speak with, notes from conversations, and any written documentation you receive. Download our free Appeals Tracking Form (TriageCancer.org/AppealTrackingForm) to help stay organized, and consider asking a family member or friend to help you manage documents and take notes during calls.
    - Keep copies of everything that is submitted throughout the process
    - When you need to mail physical copies, send items via certified mail so that you have proof of the date that items were sent. If your deadline is close, mail your documents early or ask about submitting them electronically, because a postmark may not show the date you mailed it. See *Submitting Paperwork* for more tips.
3. **Open all of your mail.** It is important to open and read every letter from your health insurer and every bill from your health care providers, because a denial letter can start the clock on your deadline to appeal. You should also check your health insurer's online portal and your patient portal, since some notices may only be posted there.

[3] 45 CFR § 147.136(b)(2)(ii)(E).

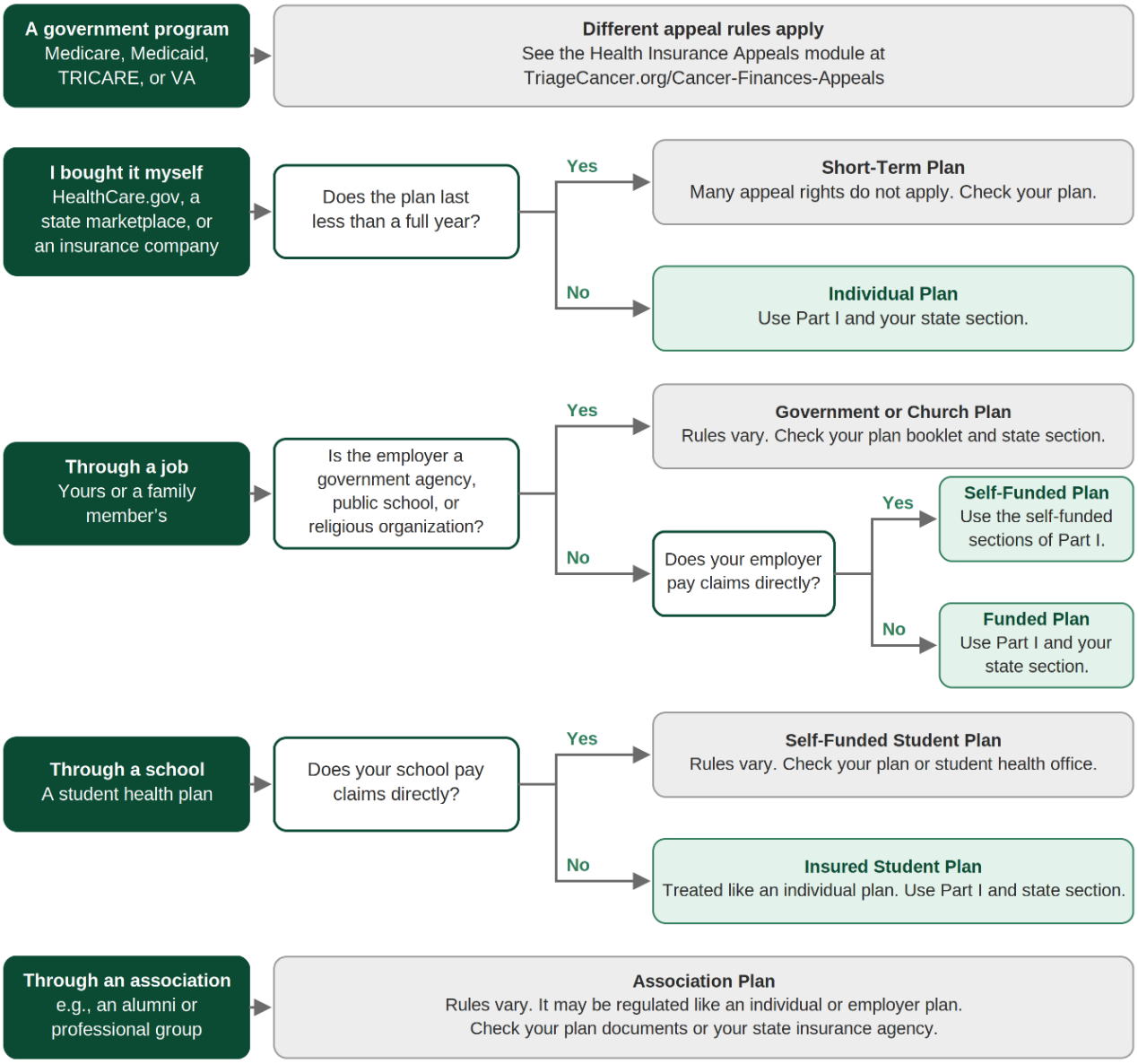
4. **Start gathering evidence early.** As soon as you receive a denial, start collecting the documents you'll need for your appeal, including:
    - your medical records;
    - any notes or letters from your health care team;
    - and the specific information the health insurer requires (member ID, dates of service, claim reference number).

The section below on Building the Case for Your Appeal covers what evidence matters most and how to make the strongest argument.

5. **Pay attention to deadlines.** Missing a deadline can affect your ability to appeal. Put these deadlines in whatever system you usually use to keep track of appointments (e.g., datebook, wall calendar, smartphone).
    - If you miss a deadline, do not assume your appeal rights are gone. Depending on your plan type and circumstances, you may still have options:
        1. **Contact your health insurer immediately.** Explain why the deadline was missed and ask whether an exception can be made. In some cases, health insurers will accept a late appeal, particularly if the delay was due to a medical emergency, an administrative error, or circumstances outside your control.
        2. **Check whether your state offers additional protections.** Some states require health insurers to accept late appeals under certain circumstances. Check the state-specific section of this toolkit for information about your state.
        3. **Consider filing a complaint.** If you believe the deadline was unreasonably short or that your health insurer failed to clearly communicate it, you can file a complaint with your state's insurance regulator. See the complaint guidance in Part II for more information. Keep in mind, this is a regulatory complaint, not an appeal or a grievance; see the Key Terms section above for the difference.
        4. **Consult with a patient advocate or attorney.** If a significant coverage amount is at stake, it may be worth seeking guidance from a patient advocate or attorney who specializes in insurance disputes. Suggestions on where to find assistance are included at the end of this Toolkit.
6. **Write with purpose.** You will need to submit a written reason for your appeal. Give specific reasons why your claim should be paid under your policy, explain why your procedure or medication is medically necessary, and include supporting evidence. The Building Your Case section below covers how to gather that evidence and write a strong appeal.
7. **Be patient and persistent.** You may need to go through several levels of appeals before getting the answer you want. Do not be discouraged if your first appeal is denied. Each level is an opportunity to build a stronger case, and many people do ultimately succeed.

What Type of Health Insurance Do You Have?

Find where your health insurance comes from on the left, then follow the arrows.



Not sure if your employer or school plan is self-funded?

Check your Summary Plan Description (SPD) or plan documents for "self-funded," "self-insured," or an insurance company listed as the "claims administrator." Or ask HR or your school: "Is our health plan self-funded or fully insured?"

Is your plan "grandfathered"?

A plan that has existed since March 23, 2010, without major changes may be grandfathered. These plans do not have to follow many appeal rules. Your plan documents must say if your plan is grandfathered.

Is it a health care sharing ministry?

Health care sharing ministries are not health insurance, so the appeal rights in this toolkit do not apply. Check your membership documents for how to dispute a decision.

If you still are not sure what type of health insurance you have, you can always call the number on the back of your health insurance card or contact whoever helped you sign up for the policy (e.g., insurance agent, employer) to ask what type of plan you have. Learn more about health insurance: TriageCancer.org/HealthInsurance.

Steps to Appeal by Type of Insurance

This section specifically explains the appeals processes for individual and employer-sponsored health insurance. Successful appeals require that you understand the rules based on the type of health insurance plan you have.

Government-Sponsored Health Insurance

If you have Medicare, Medicaid, TRICARE, or VA Health you can find more information about those appeals in the CancerFinances.org module on Health Insurance Appeals: TriageCancer.org/Cancer-Finances-Appeals.

Other Types of Health Insurance

If you have another type of health insurance plan, you should contact the company or organization from which you purchased your coverage to ask about its appeals process. For example, people with self-funded student health plans or non-federal governmental plans, which may follow different rules, should contact their plan administrator or benefits office to learn about their appeals options. Self-funded plans that are not covered by ERISA, such as church plans and plans for state or local government employees, may use either a state or federal external review process. Your denial notice should tell you which process applies to your plan.

Individual Health Insurance Plans or Funded Employer-Sponsored Health Insurance Plan

For both individual health insurance plans and funded employer-sponsored health insurance plans, generally, there are two levels of appeals: internal and external. Internal appeals go to your health insurer, while external appeals go to an independent organization.

Internal Appeals for Individual Plan or Funded Employer-Sponsored Health Plan

Each company may have a different internal appeals process, and you must follow that process exactly. Information about the appeals process should be included in your denial letter. If you aren't sure about your health insurer's process, contact the company and ask for it in writing. Some states had their own appeal laws before federal appeal rules took effect in 2010, and not all of those laws have been updated. Federal rules set the minimum protections for most plans. If a state law gives you less time or fewer protections than federal rules, your health insurer must follow the federal rules. If a state law gives you more protection, your health insurer must follow the state law. Part II of this toolkit explains how this works in your state.

Health insurers are now required to have an appeals process that:

- includes a process when appealing coverage rescissions (i.e., retroactive cancellation of coverage)
    - Note: the ACA forbids health insurers from canceling your policy, unless you stop paying your premiums, you commit fraud on your application, or you leave off important information on purpose. Without this protection, people with pre-existing medical conditions might find their policies cancelled after submitting an expensive claim that the health insurer doesn't want to pay.
- requires notices be provided in a non-English language if asked

- ensures that decision makers do not have conflicts of interest (e.g., the people who decide claims and appeals cannot be hired, paid, or promoted based on how likely they are to deny claims, which would give them a personal stake in denying your care)[4]
- provides continued coverage for an ongoing course of treatment while waiting for the outcome of an appeal (e.g., if you are in the middle of chemotherapy and your health insurer decides to stop covering it, your coverage should generally continue until your appeal is decided)[5]. See *Continuing Care During the Appeals Process* for more information.

If you are denied and disagree with the health insurer's decision, you may have the right to file an internal appeal. There are two types of internal appeals:

- **Standard appeal**. For situations that are not urgent, a standard appeal can be filed within 180 days of receiving the denial.[6]
    - Pre-Authorization: the health insurer is required to provide an answer, in writing, within 30 calendar days of receiving an appeal
    - Post-care Claims: the health insurer is required to provide an answer, in writing, within 60 calendar days of receiving an appeal
- **Expedited appeal**. An expedited, or urgent, appeal can be filed if you haven't received treatment yet or are in the middle of treatment and your health care providers believe that a delay in access to care would cause an imminent or serious threat to your health. The health insurer is required to respond to the urgent appeal within 72 hours of receiving the appeal.
    - Generally, the 72 hours include nights, weekends, and holidays, and they start when your health insurer receives your appeal, even if it does not have all of the information it needs yet. You can usually request an urgent appeal by phone, but make sure to ask for written confirmation of the date and time your appeal was received. If your health insurer tells you its decision by phone, it must follow up with a written notice within three days.

Type of appeal	Reason for appealing	When patient should submit appeal	Timeline for decision from health insurer
Pre-authorization appeal	Denial before care received. Denial prevents patient from receiving care	Within 180 days	Within 30 days of initial appeal
Post-treatment appeal	Denial for payment of care already received, meaning patient is 100% responsible for any charges	Within 180 days	Within 60 days of appeal
Urgent care (or expedited) appeal	Delay in treatment would seriously jeopardize life or overall health, affect the patient's ability to regain maximum function, or subject them to severe and intolerable pain	Within 180 days. But if urgent, patient can ask for external review at the same time as internal review.	Within 72 hours of receiving appeal

[4] 45 CFR § 147.136(b)(2)(ii)(D).
[5] 29 CFR § 2560.503-1(f)(2)(ii).
[6] 29 CFR § 2560.503-1(h)(3)(i) (180 days to appeal) and (i)(2) (decision deadlines).

During the appeals process, you are entitled to “full and fair review,” which means health insurers must show you any evidence that they use to make their decision. They cannot charge you to see this information. You must also be given the opportunity to review your entire claim file and present evidence and testimony as part of the internal appeals process. If your health insurer considers new evidence or comes up with a new reason for denying your claim during the appeal, it must give you that information for free before it makes its final decision. It must also give you a reasonable amount of time to respond.[7]

If you have an individual health insurance plan, there is only one level of internal appeal.[8] If you have a funded employer-sponsored plan, your plan may have up to two levels of internal appeal. If there are state-specific rules related to levels of internal appeals, those details can be found in Part II of this toolkit.

In some cases, a health insurer may use an additional process known as peer-to-peer review. During this process, a health insurer reviewer will communicate directly with the health care provider, who ordered the denied medical care, and give them an opportunity to explain why the medical care is needed. Generally, the reviewer should be a health care professional with the appropriate training and experience in the field of medicine related to the patient’s care.

Federal rules require that appeals involving medical judgment be decided in consultation with a health care professional who has appropriate training and experience in the relevant field (see *Check the Reviewer’s Qualifications* below).[9] Because a peer-to-peer review can directly influence the final coverage decision, there is a strong basis to argue that this same standard should apply. If your health care professional believes the reviewer lacks the relevant experience, they can ask for a different reviewer. The request should be made in writing, explaining why the assigned reviewer is not clinically appropriate.

If your provider is contacted for a peer-to-peer review, here are some practical steps providers can take to help make the most of the process:

- Ask for the reviewer's credentials in advance to assess whether the reviewer has relevant specialty experience.
- Prepare a concise clinical summary that clearly explains the diagnosis, the treatment being requested, and why it is medically necessary for this specific patient.
- Reference clinical guidelines and evidence, such as NCCN guidelines or published studies, to support the case. Health insurers are more likely to reverse a denial when the appeal is grounded in established standards of care.
- Take notes during the call, including the reviewer's name, credentials, and the key points discussed.
- Follow up in writing after the call, to confirm what was discussed and request a written decision

Even if you lose the peer-to-peer review, you may still have the ability to file an external appeal. In most cases, you are required to exhaust your health insurer’s internal appeals process before you can seek an external appeal. But, in some urgent situations, you may be able to file the internal and external appeals at the same time and receive an answer from both in 72 hours.

[7] 45 CFR § 147.136(b)(2)(ii)(C).
[8] 45 CFR § 147.136(b)(3)(ii)(G).
[9] ACA (45 CFR § 147.136) and ERISA (29 CFR § 2560.503-1)

External Appeals for Individual Plan or Funded Employer-Sponsored Health Plan

In addition to an internal appeal, you have the right to file an external appeal. This process is sometimes called external medical review (EMR) or independent medical review (IMR). Many states have laws that created the right to access EMR, and the ACA made it federal law. Through EMR, an independent review organization, rather than your health insurer, will review the appeal and make a decision that is binding on both of you.

You can request an external appeal when:

- You've completed the internal appeal;
- Your health insurer does not follow the internal appeals rules (e.g., it does not make a decision within the required time frame)[10];
- Your health insurer waives the internal appeal requirement; or
- You have an extremely urgent issue and you ask for the external appeal at the same time as the internal appeal.

In non-urgent situations, you must file your external appeal within four months from when you get written notice from your health insurer that the internal appeals process is over. An external appeal is an option if the denial is because the health insurer claims that:

- The service is not medically necessary;
- The service is experimental or investigational; or
- The denial involves whether your health insurer followed the No Surprises Act (e.g., it processed a surprise bill as if the provider were out-of-network).
  You can also file an external appeal for a rescission (cancellation) of coverage for a reason other than nonpayment of premiums.

External appeals generally do not apply to denials that only involve the terms of your plan or a legal question (e.g., whether a service is listed as excluded), without any medical judgment. However, the IRO decides whether your claim involves medical judgment. If you are unsure, you can still request an external appeal.

All states are required to offer an external appeal process that meets the consumer protection rules in the ACA.[11] In many states, the process includes more protections than the federal law, like extra levels of review or the right to appear at hearings. You can learn more about the process for each state in Part II of this toolkit.

State law generally requires your health insurer to tell you how to ask for an external appeal.
In the few states without a qualifying external review process, your health insurer must provide external review through either the HHS-administered federal external review process or through a private accredited independent review organization (IRO). Your denial notice should tell you which process applies to you.

What Your External Review Must Include

Under federal law, external appeals must include:

- **A real right to review.** You can request an external appeal of any denial based on medical necessity, appropriateness, care setting, level of care, or whether a covered benefit is effective for your situation. Denials involving experimental or investigational treatment must go through a special external review process.

[10] 45 CFR § 147.136(b)(2)(ii)(F).
[11] 45 CFR § 147.136(c) and (d).

- **Clear written notice of your rights.** Your health insurer must tell you, in writing, how to ask for an external appeal and what your rights are.
- **At least four months to file.** You have at least 120 days from the date you receive your final internal denial to ask for an external appeal.
- **A fast track when you need it.** If waiting for a standard external appeal would seriously harm your health, you can ask for an urgent external appeal. You can also skip the internal appeal and go straight to an external appeal in urgent situations, or if your health insurer waives the internal appeal requirement.
- **Timely decisions.** A standard external appeal must be completed within 45 days. An urgent appeal must be completed as quickly as possible, and no later than 72 hours after the IRO receives your request. If the IRO gives you its decision by phone, it must follow up in writing within 48 hours.
- **An independent reviewer.** The review is conducted by an Independent Review Organization (IRO) with no financial or professional stake in the outcome. IROs are assigned in a way that ensures independence, and the state agency overseeing the process must confirm each approved IRO has no conflicts of interest.
- **No cost barrier.** Your health insurer pays for the IRO's work. You may be charged a filing fee of no more than $25, but the fee must be refunded if you win, waived if paying it would be a financial hardship, and you cannot be charged more than $75 in filing fees in a single plan year. The federal external review process is free. There is no minimum dollar amount your claim must be to qualify for an external appeal.
- **A chance to add your evidence.** You generally have five business days to submit additional written information for the IRO to consider, and the IRO must share it with your health insurer.
- **A binding decision.** The IRO's decision is binding on both you and your health insurer, although, you may still have other legal options under state or federal law. If the IRO reverses the denial, your health insurer must immediately provide coverage or payment for your claim.

The Federal External Review Process

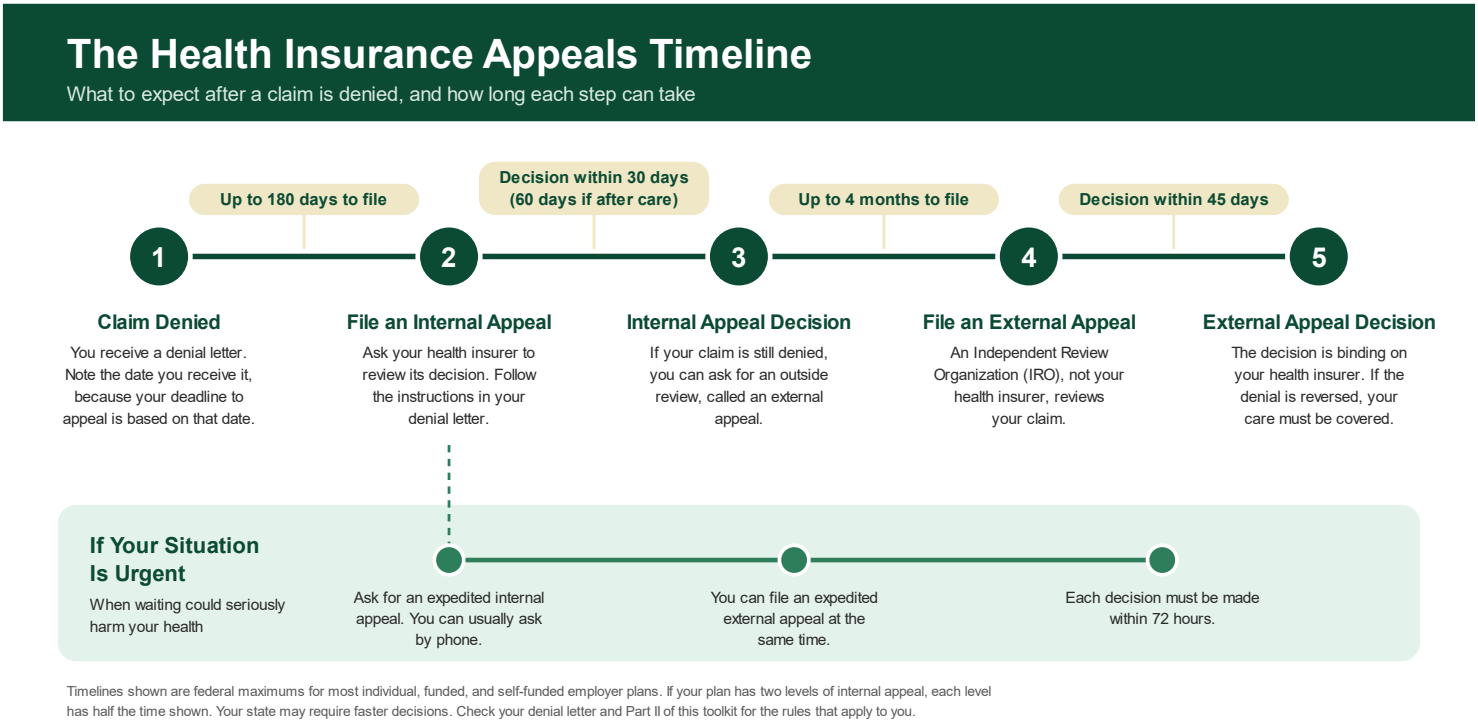
If your state does not have a qualifying external review process, or if you have a self-funded employer plan, your external appeal will go through a federal process. There are two federal processes, both are free to use, and your denial letter should tell you which one applies to you:

- **HHS-Administered Federal External Review Process (FERP):** The U.S. Department of Health & Human Services (HHS) contracts with a company called Maximus Federal Services to handle these external appeals. As of 2026, this process is often used by people with individual or funded plans who live in Alabama, Florida, Georgia, Texas, Wisconsin, or a U.S. territory (other than Puerto Rico), and by many people with a state or local government plan.
- **Private Accredited IRO Process:** Some health insurers, and most self-funded employer plans, contract directly with an IRO instead. If this applies to you, you will usually request an external appeal by following the instructions in your final denial letter or Summary Plan Description, and your health insurer will send your case to an IRO.

How the HHS-Administered Process Works

- **Deadline:** You generally have four months after you receive your final denial to request an external appeal.
- **How to File:** You can submit your request online at ExternalAppeal.CMS.gov, or complete the HHS Federal External Review Request Form and send it to Maximus by mail or email.
    - Email: ferp@maximus.com
    - Mail: Maximus Federal Services, 3750 Monroe Avenue, Suite 708, Pittsford, NY 14534.

    - Call Maximus toll free at 1-888-975-1080 to request a form or ask questions.
- **If Someone Else Is Filing for You:** You and your representative will both need to complete and sign the HHS Federal External Review Process Appointment of Representative form. In urgent situations, a health care professional who knows about your medical condition can request an external appeal for you without this form.
- **What to Include:** Your request should include a copy of your denial letter, and you can include other documents that support your appeal, such as letters from your health care provider, medical records, and EOBs. If you do not send additional information, the reviewer may decide your appeal based only on the information your health insurer provides.
- **Timeline:** Maximus must send you its decision no later than 45 days after it receives your request. If your situation is urgent, you can ask for an expedited review, and a decision must be made no later than 72 hours after your request is received.
- **The Decision:** The decision is binding on your health insurer. If the denial is reversed, your health insurer must provide coverage or payment for your claim.



Self-Funded Employer-Sponsored Health Plans

In self-funded plans, also called self-insured plans, the employer is the one actually paying for your health care claims. While self-funded plans are most common among large companies, smaller businesses may also self-fund their employee's health care.

It is common for people not to know if their employer-sponsored health plan is funded or self-funded. In fact, you may not be able to tell just by looking at your insurance card, because most employers that self-fund contract with an insurance company to administer their plan (e.g., pay claims, mail out EOBs). So, you may have an insurance card with an insurance company logo on it, but the plan may actually be self-funded.

If you are not sure if your plan is self-funded, reach out to your HR representative or whoever handles your employee benefits at work. You can also call the number on the back of your insurance card and ask the company if they are the “third party administrator” or “the insurer.”

Most self-funded employer plans are governed by a federal law called the Employee Retirement Income Security Act of 1974 (ERISA). ERISA generally overrides state insurance laws, which means self-funded plans are not required to follow many of the state protections that apply to funded plans. This is important to understand, because it means state consumer protections, such as state external review processes, state laws limiting copay accumulators, or state laws providing access to biomarker testing or fertility preservation, may not apply to you.

ERISA also sets the rules for what self-funded plans are and are not allowed to do. For example, ERISA:

- requires health plans to let policyholders (i.e., you) see their plan documents
- forbids plans from charging a fee to file an internal appeal
- caps internal appeals at two levels before you can file an external appeal
- requires plans to provide notices of adverse benefit determinations (ABDs) and an opportunity for appeal
  requires that the appeals process be explained in the summary plan description (e.g., appeals must be requested in writing)

If you have a self-funded plan, you should request a copy of your Summary Plan Description (SPD) as soon as possible after a claim is denied. ERISA requires your employer to give you the SPD within 30 days of when you ask.[12] The SPD outlines your health insurer's specific claims and appeals procedures, which you will need to follow exactly.

Internal Appeals for Self-funded Employer-Sponsored Health Plans

Appeal rules under ERISA have changed several times over the years, including under the ACA. You generally have at least 180 days from the date on your denial notice to file an internal appeal. Check your denial letter and SPD for your exact deadline. Then the health insurer has to respond within a certain amount of time. That time frame depends on the type of appeal you are filing.

- Urgent Appeal (when waiting for a decision could seriously harm your health): A decision should be made as soon as possible, but not more than 72 hours after the health insurer receives the urgent appeal.
  - Generally, the 72 hours include nights, weekends, and holidays, and they start when your health insurer receives your appeal, even if it does not have all of the information it needs yet. You can usually request an urgent appeal by phone, but make sure to ask for written confirmation of the date and time your appeal was received. If your health insurer tells you its decision by phone, it must follow up with a written notice within three days.
- Pre-Authorization (a decision before you get care): If there is one level of appeal, the health insurer must decide within 30 days of receiving your appeal. If there are two levels of appeal, a decision should be made within 15 days, for each level.
- Post-care Claims (a decision after you got care): If the plan has one level of appeal, the health insurer must decide within 60 days of receiving your appeal. If there are two levels of appeal, a decision should be made within 30 days, for each level.

[12] ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4). A court may order a plan administrator who does not provide requested plan documents within 30 days to pay up to $110 per day. 29 U.S.C. § 1132(c)(1); 29 CFR § 2575.502c-1.

Type of appeal	Reason for appealing	How long does the patient have to appeal?	Timeline for decision from health insurer
Pre-authorization appeal	Denial before care received. Denial prevents patient from receiving care	At least 180 days	If one level of appeal: 30 days If two levels of appeal: 15 days
Post-treatment appeal	Denial for payment of care received, meaning patient is 100% responsible for any charges	At least 180 days	If one level of appeal: 60 days If two levels of appeal: 30 days
Urgent care (or expedited) appeal	Delay in treatment would seriously jeopardize life or overall health, affect the patient's ability to regain maximum function, or subject them to severe and intolerable pain	At least 180 days	As soon as possible, not longer than 72 hours

To start the internal appeals process, follow the instructions on your denial letter.

If your internal appeal is denied, the health insurer must give you a written notice (either electronically or in the mail) that includes:

- The specific reasons for denial (e.g., not medically necessary, not covered)
- The specific plan provision that they relied on for the denial
- A description of any voluntary options the health insurer offers to resolve disputes (e.g., additional appeal levels or arbitration)
- A statement that you have the right to receive, free of charge, any documents relevant to your claim (including the records used to make the decision)
- A description of your right to file a case in court

External Appeals for Self-funded Employer-Sponsored Health Plans

If you have exhausted the internal appeals process for your self-funded employer-sponsored health plan, you have the right to an external appeal. Self-funded plans must follow a federal external appeals process. Some self-funded plans voluntarily follow a state external appeals process instead, but they are not required to. Most self-funded plans use the Private Accredited IRO Process described in The Federal External Review Process. Follow the instructions in your final denial letter or Summary Plan Description to request an external appeal.

Usually, claims involving “medical judgment” and rescissions are subject to federal external review. “Medical judgment” includes claims for:

- Medical necessity (e.g., your health insurer says a PET scan is not needed)
- Appropriateness of care (e.g., your health insurer says a different treatment would work just as well)
- Health care setting (e.g., your health insurer will cover an infusion at an infusion center, but not at a hospital)
- Level of care (e.g., your health insurer will cover a skilled nursing facility, but not an inpatient rehabilitation hospital)

- Effectiveness of a covered benefit (e.g., your health insurer says radiation would not be effective for your type of cancer)
- Determination as to whether a treatment or procedure is experimental or investigational (e.g., your health insurer says a drug has not been proven to work for your diagnosis)

Whether a claim involves "medical judgment" is decided by the external reviewer, not by you or your plan. Self-funded plans usually contract with accredited Independent Review Organizations (IROs) to handle external appeals. So, in practice the IRO will make the decision about whether your claim qualifies for an external appeal.

The person who reviews your appeal, whether internal or external, cannot be the same person who made the initial denial. If the decision involves medical judgment, the reviewer must consult a qualified health care professional who was not involved in the original decision.

Filing a Lawsuit for Self-funded Employer-Sponsored Health Plans

It is important to note that participants are generally required to exhaust the internal appeal process before filing an ERISA claim for denial of benefits. If you have a self-funded employer-sponsored health plan, the external appeal decision is binding on the plan. However, if you do not win the external appeal, you still have the right to sue in federal court.[13]

Keep in mind that in this type of case, you can usually only recover the value of the benefit denied under your plan's terms, enforce your rights under the plan, or clarify your rights to future benefits.[14] What you recover may be less than the full amount you were billed, because plans generally pay based on their contracted or allowed amounts rather than the sticker price. Some courts may also allow you to collect interest or attorneys' fees, but that is not guaranteed.

For example, Maria's health insurer denied coverage for her surgery, and the hospital billed $50,000. Under her plan, the allowed amount for the surgery is $30,000, and Maria has 20% co-insurance. If Maria wins her lawsuit, the court may order her plan to pay $24,000 (80% of $30,000), which is what the plan should have paid. Maria would still be responsible for her $6,000 co-insurance. Generally, Maria could not recover money for other harms, such as stress or a delay in her care. Also, if the hospital was out-of-network, Maria may owe the difference between the bill and what her plan pays.

For many claims, especially those involving a single denied service, the cost of hiring an attorney may be more than the amount you could win in the lawsuit. ERISA lawsuits are typically most useful when the amount at stake is very high or when the denial affects ongoing care that you need.

If you decide to file a lawsuit, you may consider hiring an attorney. The Finding Legal Assistance (TriageCancer.org/Cancer-Finances-Legal-Assistance) module on CancerFinances.org has more information about how to hire an attorney for this type of legal issue.

[13] ERISA section 502(a)(1)(B)
[14] 29 U.S. Code § 1132

Practical Considerations Related to Self-funded Employer-Sponsored Health Plans
In self-funded plans, the employer is paying directly for an employee's health care. Therefore, when appeals are filed, the employer may play a role in the approval and denial process. As a result, some employees are nervous to file an appeal or a lawsuit for fear of losing their job. However, ERISA section 510 prohibits employers from interfering with benefits or retaliating against an employee for exercising their rights under ERISA (e.g., filing an appeal).

If you believe your employer is not complying with ERISA, or has retaliated against you for filing an appeal, at any stage in the appeals process, you may contact the Employee Benefits Security Administration (AskEBSA.dol.gov/WebIntake/Home.aspx) (EBSA) at the U.S. Department of Labor (DOL) or call 866-444-3272 for assistance.

If your plan uses a third-party administrator to handle claims (which is common), your employer generally does not see the details of your specific health care claims or appeals. That separation can be reassuring to you, if you are worried about your employer learning about your health through the appeals process.

Grandfathered Plans
Under the ACA, employer plans that were created before March 23, 2010, and have stayed substantially similar since then, may be considered "grandfathered." To figure out if your plan is grandfathered, keep in mind that the date you joined the plan may not be the same as the date the plan was created. New employees and family members may be added to existing grandfathered plans after March 23, 2010. If you are unsure if you have a grandfathered plan, contact the person at work who handles employee benefits to ask (e.g., HR, benefits department, or the person you turn in your timesheet to).

Grandfathered health plans are not required to comply with some of the consumer protections in the ACA, including the ACA's internal and external appeals rules. But, they still must comply with other laws, and self-funded grandfathered plans are still subject to ERISA's appeals rules.
However, if your denial involves whether your health insurer followed the No Surprises Act, you may still be able to request an external appeal, even if you have a grandfathered plan.

If you have a grandfathered plan and receive a denial of coverage, you may file an appeal with the health plan. Follow the specific rules provided by the plan to appeal. If you lose your first appeal, the plan may offer you additional levels of appeal.

If your grandfathered plan is a self-funded employer-sponsored health plan, you should also read the section on Self-Funded Employer-Sponsored Health Plans, as ERISA rules still apply to you.

If your grandfathered plan is funded, some of the state protections discussed in Part II may also apply.

Even if you have a grandfathered plan, many of the practical tips discussed in this toolkit can still be useful.

Building the Case for Your Appeal

A successful appeal is about more than meeting deadlines. Building a strong case with the right information and supporting documents can improve your chances of winning your appeal.

Using Federal Rules to Support Your Appeal

Throughout this toolkit, you will see footnotes that cite the federal rules behind some of your most important appeal rights. You do not need to read these rules to file an appeal. But if your health insurer will not follow one of them (e.g., it will not send you a copy of your claim file, or it misses a deadline), it can help to cite the rule in a written request or appeal letter. For example: “Under 29 CFR § 2560.503-1(h)(2)(iii), I am requesting a free copy of all documents, records, and other information relevant to my claim.” Citing the specific rule shows that you know your rights, and it may help get your request to someone who can resolve it.

Most of these rules apply to individual plans, funded employer plans, and self-funded employer plans, but grandfathered plans may not have to follow all of them. You can read any of these rules for free at eCFR.gov.

Ask For Your Claim File

One of the most useful and underused steps in the appeals process is asking for your claim file. Your claim file is the complete record that your health insurer used to decide your claim. It usually includes the notes from the claim reviewer, the specific medical policy or coverage guidelines they applied, the expertise of anyone who used their medical judgment to decide the claim, and any documents your health care provider submitted with the claim. It may also include internal correspondence and the specific reasons your claim was flagged for review or denial.

You have the right to ask for your claim file for free.[15] For ERISA plans, this right comes from federal law: the plan must provide, on request and at no charge, all documents, records, and other information relevant to your claim. For non-ERISA plans, the ACA's internal appeals rules require health insurers to give you access to the information used to make the decision, for free.

Asking for your claim file is useful, because it often includes information that will help you make your appeal stronger:

- The reviewer's actual reasoning to deny your claim, which may be based on incomplete information or a misreading of your records
- The specific medical policy your plan applied, which you can then compare against clinical guidelines and your own situation
- If the reviewer had the appropriate expertise to evaluate your case (for example, whether a specialist reviewed a specialty question)
- Any gaps between what your provider submitted and what the plan considered

Contact your health insurer in writing and ask for "a copy of my complete claim file, including all documents, records, and other information relevant to my claim, at no cost, as required by federal law." Send the request by certified mail or using a method that gives you confirmation of receipt.

Response times depend on the type of plan you have. For self-funded employer-sponsored health plans, federal rules do not set a specific deadline, but the plan must provide the documents on request, and in time for you to use them in your appeal. For individual health plans and funded employer-sponsored health plans, the ACA does not set a separate deadline by which the health insurer must provide the claim file. Instead, your health insurer must give you access to this information as part of the appeal process itself, and in enough time for you to use it before your appeal deadline. Because of that, it is best to request your claim file as soon as possible after receiving a denial, so you have time to review it and incorporate what you find into your appeal.

[15] 29 CFR § 2560.503-1(h)(2)(iii).

Check the Reviewer's Qualifications

Federal rules set standards for who can review your appeal. If your denial was based on medical judgment (e.g., your health insurer decided that your care is not medically necessary or is experimental), it must consult with a health care professional who has the appropriate training and experience in the field of medicine involved in your care. For example, if your appeal involves a cancer treatment, a reviewer without experience in treating cancer may not have the appropriate expertise. The person who reviews your appeal also cannot be the person who made the original denial, or someone who reports to that person.[16]

You have the right to ask your health insurer to identify any medical experts it consulted about your claim, even if it did not follow their advice.[17] If the reviewer did not have the appropriate expertise, you or your health care provider can point this out in your appeal and ask for a new review by a qualified reviewer.

In an external appeal, the IRO must generally assign a clinical reviewer who is an expert in treating your medical condition, who has recent or current experience treating patients with the same or a similar condition, and, if the reviewer is a physician, who is board certified in the appropriate specialty.[18] Some states also have laws with additional requirements, such as requiring the reviewer to be in the same or a similar specialty as the health care provider who recommended your care. Check Part II for information about your state.

What If You Have Concerns About the Reviewer's Qualifications?

If you are concerned about who is reviewing your appeal, here are some steps you can take:

- **Ask in Writing:** Send a written request to your health insurer asking for the name, specialty, and credentials of anyone who reviewed your claim or appeal, and any medical experts it consulted. Keep a copy of your request and note the date you sent it. You can also ask for this information as part of your request for your claim file.
- **Raise the Issue in Your Appeal:** If the reviewer does not appear to have experience treating your medical condition, say so in your appeal and ask for a new review by a qualified reviewer in the appropriate specialty. Your health care provider can also address this in their letter of medical necessity, explaining why a reviewer in their specialty is needed to evaluate your care.
- **Peer-to-Peer Reviews:** Your health care provider can ask for the reviewer's credentials before the call. If the reviewer is not in an appropriate specialty, your provider can ask, in writing, for a peer-to-peer review with a reviewer who is.
- **If Your Health Insurer Won't Respond:** Note this in your appeal. If your health insurer does not follow the rules for the internal appeals process, you may be able to move directly to an external appeal. You can also file a regulatory complaint with your state's insurance agency or, if you have a self-funded employer plan, with the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). If you later file a lawsuit, a health insurer's failure to follow these rules may also be relevant.
- **Ask for an External Appeal:** In an external appeal, the IRO makes its own decision about your claim. It does not rely on your health insurer's reviewer, and it must assign a clinical reviewer who meets the qualifications described above.

In an external appeal, you generally will not be told the name of the IRO's clinical reviewer. If you have concerns about the IRO or its reviewer, contact your state's insurance agency, which oversees the state

[16] 29 CFR § 2560.503-1(h)(3)(iii) and (v).
[17] 29 CFR § 2560.503-1(h)(3)(iv).
[18] 45 CFR § 147.136(c)(1) (incorporating NAIC Uniform Health Carrier External Review Model Act § 13(B) (2010)).

external review process. If your appeal went through the HHS-administered federal process, you can contact HHS at externalappeals@cms.hhs.gov.

Work With Your Health Care Team

Your health care team can play an important role in helping you file a successful appeal. Some key steps your health care team can take, include:

- Correcting codes for services to make sure they match your treatment and the codes that are covered by your health insurance plan
- Providing documents that demonstrate your treatment is medically necessary
- Serving as an authorized representative during the appeals process

Service Codes

A common reason that a claim gets denied is because the treatment was coded in a way that did not fall within the scope of the health plan. For example, a PET scan to check whether cancer has come back may be denied if it is billed with a code that does not show your history of cancer. Or, a medication may be billed under your medical benefit when it should have been billed under your pharmacy benefit. By correcting the code for a treatment or medication, an insurance denial can quickly become an approval without having to go through an extended appeals process.

Coding is typically handled by your health care provider's billing office, not the health care provider directly. If you think a coding error may have caused your denial, ask your health care provider or their billing staff to review the codes used. Although this may not always be the reason the claim is denied, it may be a good place to start.

If your claim involves a surprise bill, and you and your health insurer disagree about whether it was coded correctly, that decision may be eligible for an external appeal.

Documentation

A key part of a successful appeal is being able to provide documentation showing that the denied health care is medically necessary. Even though you might be able to make a good argument on your own, having documentation provided from your health care provider can significantly improve your chances of winning your appeal. While gathering information for your appeal, you should ask your health care team for documentation that shows why the care you are asking for is medically necessary, including any relevant x-rays, blood test reports, and scans. You can also ask a member of your health care team to write a letter explaining specifically why the health care is medically necessary. They are in the best position to explain why they recommended that health care and why you need it.

Evidence of Medical Necessity

Getting information from your health care team is a great place to start. But sometimes gathering evidence from other sources can strengthen your case for why the treatment should be covered.

The following sources can help you find evidence to support your appeal:

- Your policy documents: Many plans publish their coverage policies (sometimes called "medical policies" or "coverage determination guidelines") on their websites. Citing the plan's own policy back to them can be some of the strongest evidence in an appeal, because you are showing that your treatment meets criteria the plan uses. Check your health insurer's website or ask member services how to access these policies.

- Clinical practice guidelines from professional medical societies: Many medical societies publish treatment guidelines that can support an appeal. Examples include the American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), and American Society for Radiation Oncology (ASTRO), among many others. Ask your health care team which society's guidelines apply to your specific medical condition and treatment, and whether those guidelines support your case.
- National Comprehensive Cancer Network (NCCN.org): A not-for-profit alliance of cancer centers, the NCCN publishes clinical treatment guidelines that are widely used as the standard of care in oncology. Their guidelines can be strong evidence that a requested treatment is medically necessary.
- PubMed (PubMed.ncbi.nlm.nih.gov): Sponsored by the National Library of Medicine, PubMed is a database that collects citations from various biomedical literature sources including the results of recent research trials.
- National Cancer Institute (Cancer.gov): The National Cancer Institute provides a collection of current research related to emerging cancer treatments.
- Drugs@FDA (AccessData.FDA.gov/Scripts/CDER/DAF): A searchable database maintained by the FDA that includes FDA approvals, drug labels, and review documents. This can be useful for showing that a drug is FDA-approved for a specific use.
- DailyMed (DailyMed.nlm.nih.gov): A service of the National Library of Medicine that provides the official FDA drug labeling, including approved indications, dosing, and warnings. Useful for establishing that a treatment is being used for a standard, approved indication.
- ClinicalTrials.gov: A registry maintained by the National Library of Medicine that lists ongoing and completed research studies. Useful for showing that a treatment is under active clinical investigation rather than experimental.

If you decide to look for resources on other websites, be sure the source is reliable. You can always discuss any information you find with your health care team to get advice on whether it would be helpful to include the information in your appeal.

Personal Statement

Some health insurers require, or allow, you to submit a personal statement as part of your appeal. A personal statement is a letter, written by you, that describes how the denial affects your health and your daily life (e.g., treatments you have already tried, side effects you have experienced, or delays in your care). You can use the Triage Health Appeals Navigator (TriageCancer.org/Triage-Health-Appeals-Navigator) to help build your appeal letter. A letter from your health care provider explains why the care is medically necessary, and your personal statement can help the reviewer understand how the denial affects you.

Authorized Representative

Sometimes, you may be unable or do not want to handle your appeal yourself. Many health insurers will allow you to appoint someone as your authorized representative, to file paperwork and ask for an appeal. An authorized representative doesn't have to be a member of your health care team; it can be a family member, friend, attorney, or anyone else you trust. If you do decide to appoint a member of your health care team as your authorized representative, you will need to have a very open line of communication with them, so that they can accurately reflect your preferences. This process also requires you to fill out certain forms to pick your authorized representative.

Getting the Most Out of Your Health Care Team's Help

Health care teams typically want to help their patients through the appeals process but may be limited in their time. You can help your health care team help you, by using some of these tips:

- **Be Specific**: Before asking for help, think through what you are asking your health care team to do. Are you asking them to fix a code on a claim? Are you asking for a letter of medical necessity? Are you asking for copies of your medical records? Knowing what you are asking for makes it easier for your health care team to help you.
- **Draft Sample Letters**: If you are looking for a letter of medical necessity from your provider, but they don't have time to write one, you can draft a letter for them. They can edit and sign the letter for you. The free Triage Health Appeals Navigator (TriageCancer.org/Triage-Health-Appeals-Navigator) uses AI technology to help you draft a personalized, evidence-based appeal letter based on your specific situation. You can also find sample letters and templates elsewhere online. Whatever tool you use, review the final letter carefully to make sure it accurately reflects your situation, and be thoughtful about what personal information you share. If you use a general AI tool that is not designed to protect health information, do not enter personal information, such as your name, date of birth, member ID, or medical record number.
- **Follow Up**: If you have tried reaching out to your health care provider and they haven't provided you with the information that you are looking for, don't be afraid to follow up. For example, if you requested information through an online portal and haven't heard back within a reasonable time, you can try calling your provider or making a note to remember to ask for the information during your next in person appointment.

Continuing Care During the Appeals Process

Once you have filed an appeal, you may be concerned about whether your care can continue in the meantime. If you are in the middle of a course of treatment that your plan has decided to reduce, terminate, or deny, you may be able to request that coverage continue at the same level until a final decision is made on your appeal. This is sometimes called a "continuation of benefits" request.

Talk to your health care team about your options if there is a delay in your appeal. In some cases, your provider may be able to adjust your treatment plan temporarily, identify alternative covered services until the appeal is resolved, or coordinate other access to that treatment (e.g., a financial assistance program). Keep copies of all communications related to your continuing care request, the way you would for the appeal itself.

Practical Tips for Navigating Appeals

In addition to being complicated, the appeals process can create practical barriers, especially if you don't have easy access to email, the internet, or a device that can access the internet (e.g., computer, tablet, smart phone).

Creating Accounts and Accessing the Internet

Although most of the appeals process still provides for ways to receive information physically, rather than electronically, you may reach a point in the process where someone needs to send you something by email or through an online portal. If you do not have an email address, but the system you are using requires you to have an email address to create an account, there are ways to get a free email address:

- Gmail (Workspace.Google.com/Gmail): Hosted by Google, Gmail is a free tool for creating an email address. Creating an account will also give you access to a feature known as Drive, which allows you to store files, and Calendar, which operates as an online calendar and notification tool.
- iCloud (iCloud.com/Mail): Hosted by Apple, iCloud has similar features to Gmail including access to iCloud file storage and an online calendar.

These are not the only email options, but they are a couple of places to start for setting up a free email address. Using your email account, you can sign up for other online services and create accounts on other websites, such as patient portals (e.g., through your hospital or health care provider) or a *my Social Security account (SSA.gov/MyAccount)* with the Social Security Administration.

A free email account still requires internet access. If cost is a barrier, there are some places that you may be able to access a computer and/or the internet for free:

- Public libraries
- Community or senior centers
- Religious centers
- Cancer resource centers
- A friend or family member's house

There may also be a local program that can help you get the support that you need:

- Thrift stores and refurbishers: Organizations like Goodwill, PCs for People (PCsforPeople.org), and others often sell used or refurbished computers at low cost
- The Lifeline Assistance Program (LifelineSupport.org): A federal program that provides a discount on monthly phone or internet service for individuals with low incomes. Some Lifeline providers also offer free basic cell phones and monthly service to eligible participants.
- Local nonprofit organizations: Cancer-specific and general assistance nonprofits in your area may have programs to help with technology or connectivity costs.

Once you start using email for important communications, be aware that signing up for online services can lead to junk email. Some people manage this by creating two separate email accounts, using one for important things like patient portals and government agencies, and a second one for things like store coupons and newsletters. Whatever you decide, categorizing your emails or using folders can help you keep important communications from getting lost in your email.

Submitting Paperwork

Keeping track of all the paper related to your health care can get complicated and time consuming. Especially when you only have physical copies of that paperwork, rather than electronic copies. This can also become an issue when it comes time to submit online forms that require you to attach relevant documents. There are tools available to scan physical documents to convert them to electronic copies.

- Adobe Scan (Adobe.com/Acrobat/Mobile/Scanner-App.html): A mobile application that helps you scan documents and convert them into PDFs. The app allows you to save documents and send them to yourself or others, by various methods (e.g., email).
- JotNot (JotNot.com/Scanner.html): A mobile application that allows you to digitize physical documents. The company also has apps that can help you fax documents and provide digital signatures.
- Apple Notes (Scan Documents feature): If you have an iPhone or iPad, the built-in Notes app includes a scanner. Open a note, tap the camera icon, and select "Scan Documents." Scanned documents can be saved as PDFs, emailed, and shared.
- Google Drive (Scan feature)**:** If you have an Android device, the Google Drive app includes a scanner. Open the app, tap the "+" icon, and select "Scan." Scanned documents are saved as PDFs directly to your Google Drive and can be shared or emailed from there.

If you don't have a smartphone or prefer not to use one, public libraries typically have scanners and staff who can help you scan and email documents to yourself or others.

Sometimes your appeals process will involve sending physical copies of documents instead of electronic copies. If you need to submit physical documents, here are some tips to make sure that your information is not lost:

- **Make Copies**: Before sending your documents, make copies for your own records. This can include making electronic copies or making physical copies with a scanner and printer.
- **Get Proof of When You Mailed It**: In December 2025, the U.S. Postal Service clarified that postmarks may show the date your mail was first processed at a regional processing center, rather than the date you dropped it off. If your deadline is close, it is important to have proof of the date you mailed your appeal. Here are some options:
    - **Certified Mail**: Send your documents via certified mail at the post office counter, and ask the clerk to date-stamp your receipt. The receipt shows the date you mailed your documents, and the tracking number allows you to know when your documents have been delivered.
    - **Manual Postmark**: When you take your envelope to the post office counter, you can ask for a free manual (hand-stamped) postmark. This postmark shows the date the post office accepted your mail.
    - **Certificate of Mailing**: A Certificate of Mailing is a low-cost receipt that shows the date you mailed your documents, but it does not include tracking.
    - **Electronic Submission**: Your health insurer may allow you to submit your appeal online (e.g., through a member portal) or by fax. If so, make sure to save a copy of your confirmation.
- **Organize Physical Materials**: Whether it is getting a dedicated file folder, a binder, or even a box, come up with a way that works for you, to keep track of the documents that you receive related to your health care and the appeals process.

When Is Your Appeal Considered Received?

Many deadlines in the appeals process depend on when your health insurer receives your appeal. Generally, the time your health insurer has to decide your appeal starts when you file your appeal following the instructions in your denial letter or plan documents (e.g., sending it to the address, fax number, or online portal listed in your denial letter). The clock starts even if your health insurer does not yet have all of the information it needs to decide your appeal. For example, your health insurer cannot wait until it gets a letter from your health care provider before the clock starts.[19]

How receipt is documented depends on how you send your appeal:

- **Mail:** Your appeal is usually considered received when it arrives at your health insurer, not when you mail it. The tracking information from certified mail shows when your appeal was delivered.
- **Fax:** Save the fax confirmation page showing the date, time, fax number, and number of pages sent.
- **Online Portal or Email:** Save a copy of the confirmation message, or take a screenshot showing the date and time you submitted your appeal.
- **Phone (Urgent Appeals Only):** Write down the date and time of the call, the name of the person you spoke with, and any reference number. Ask for written confirmation that your appeal was received.

Other things to keep in mind:

[19] 29 CFR § 2560.503-1(i)(4).

- **Send Your Appeal to the Right Place:** If you send your appeal to the wrong address or department, it may not be considered received until it reaches the right place. Use the contact information in your denial letter.
- **Check Your Plan's Rules for Filing Deadlines:** Some plans count your appeal as filed on the day you send it, while others count the day it is received. Your plan documents should explain which rule applies.
- **External Appeals Work the Same Way:** The IRO's time to decide your external appeal starts when the IRO receives your request.

If your health insurer says it never received your appeal, or does not decide your appeal on time, your proof of submission can help. If your health insurer does not follow the required timelines, you may be able to move directly to an external appeal, and you can file a regulatory complaint with your state's insurance agency or, if you have a self-funded employer plan, with EBSA.

Accessing Information in Another Language

If English isn't your primary language, you may have the right to ask for notices and communications from your health insurer in your preferred language, and to ask for interpreter services when speaking with them. To ask, contact your health insurer's member services line. Your denial notice may also include instructions in multiple languages for how to ask for language assistance.

Get Additional Help with Your Appeal

The appeals process can be complicated, and you do not have to navigate it alone. In addition to your health care team, there are a number of resources available to help you through the process.

Free and Nonprofit Resources

Patient navigators or financial navigators are available at no cost at most hospitals. These individuals are experienced in navigating insurance issues and can be a valuable resource throughout the appeals process. Ask your health care team whether a patient navigator or financial navigator is available to you.

Legal aid organizations may be able to assist individuals, who have lower incomes, with insurance appeals. To find a legal aid organization in your area, visit LawHelp.org.

Consumer Assistance Programs (CAPs) are available in some states to help consumers with health insurance problems, including filing appeals, for free. Check the state-specific resources in Part II to see if there is a CAP in your state. In some cases, a CAP can also file an appeal on your behalf.

Professional and Paid Resources

Certified patient advocates are professionals who specialize in helping patients navigate health care and insurance. The Patient Advocate Certification Board (PACB) certifies professional advocates. You can search for a certified advocate in your area at PACBoard.org. Certified patient advocates typically charge an hourly rate, so ask about fees upfront.

Attorneys specializing in health insurance disputes, or in ERISA specifically, may be worth consulting if you have a self-funded employer-sponsored health plan and are considering filing a lawsuit after exhausting your appeals. Some ERISA attorneys work on a contingency basis or under fee-shifting arrangements, meaning you

may not need to pay upfront. Ask about fee structures during your initial consultation. For tips on finding and working with an attorney, see our CancerFinances.org module on Finding Legal Assistance (TriageCancer.org/Cancer-Finances-Legal-Assistance).

Government Resources

Your state's insurance agency is a free resource available to you at any point during the appeals process, not just when something has gone wrong. Many state insurance agencies have consumer assistance staff who can answer questions, explain your rights under your state's laws, and sometimes help facilitate informal resolution of a dispute with your health insurer. Some states also have a managed care ombudsman program, which operates independently from the insurance agency and can provide similar help, specifically for people enrolled in managed care plans. To find your state's insurance agency, managed care ombudsman program, and other state-specific resources, visit TriageCancer.org/StateResources.

After the Appeal is Decided

Keep Your Health Care Team Informed

Once you receive a decision on your appeal, whether it is approved or denied, notify your health care team as soon as possible. If your appeal is approved, your health care team will need to move quickly to schedule or resume the approved care. If your appeal is denied, your health care team can help you figure out next steps, which may include pursuing an external appeal if you haven't already, exploring alternative treatment options, or identifying other coverage or financial assistance programs.

Throughout the appeals process, your health care team is your partner. Keeping them informed of decisions, timelines, and next steps ensures that your health care and your appeal strategy stay aligned.

If Your Appeal Is Unsuccessful: Managing the Bill

If you have exhausted your appeals process and owe money for a medical bill, you have options. First: don't ignore the bill. Ignoring medical bills doesn't make them go away, and may eliminate some of the options below.

- **Request an itemized bill and check it for errors.** Hospital bills contain errors, from duplicate charges to services that were never provided. Ask the billing office for a fully itemized bill (not just a summary), then compare it against your medical records. If you find an error, contact your provider's billing office, explain what you believe is wrong (e.g., duplicate charge, service you didn't receive, wrong code), and ask them to review and correct the bill.
- **Talk to your provider before they send the bill to a collections agency.** Providers may have flexibility to negotiate with you. Ask if they'll set up a payment plan, write off a portion of the bill, or accept a lower one-time payment to settle the bill.
- **Ask about charity care**. Nonprofit hospitals are required by federal law to have a financial assistance policy (sometimes called charity care or an "ability to pay" program) that offers free or discounted care to patients who qualify. Each hospital sets its own income eligibility rules, so someone who doesn't qualify at one hospital might qualify at another. What's covered also varies: some hospitals cover only emergency and medically necessary care, while others cover a much broader range of treatment, including outpatient cancer treatment. Hospitals must post their policy online. Under federal rules, hospitals cannot send you to collections for 240 days after your first bill if you're applying for financial assistance, but many hospitals will accept applications beyond that time, too. If your application is

denied, you can usually appeal. Dollar For (DollarFor.org) is a nonprofit organization that can check your eligibility for your hospital, help with the application, or apply on your behalf.

- **Look into help paying for prescriptions.** Drug manufacturers may offer patient assistance programs that provide medications for free or at low cost to patients who qualify. Nonprofit organizations like the HealthWell Foundation, Patient Advocate Foundation TotalAssist, and Cancer*Care* offer financial assistance programs. Eligibility rules are different for each, so it's worth checking more than one. Your health care team or the drug manufacturer can also point you toward what's available for your specific medication.
- **Don't overlook non-medical financial help.** Programs like SNAP, TANF, and LIHEAP won't pay your medical bills directly, but they can free up money in your budget to pay medical bills. The Checklist to Finding Financial Help (TriageCancer.org/Checklist-FinancialHelp) shares available programs and how to apply.
- **Be careful about how you pay medical bills.** Paying a medical bill with a credit card usually means high interest and no room to negotiate later, since the debt is now with the credit card company, not the hospital. Taking out a home equity loan is also risky, because it turns unsecured medical debt into debt backed by your house. That means that if you can't pay your monthly loan payment, the bank could take your house.

Conclusion

Navigating a health insurance denial can feel overwhelming, especially when you are focused on your health and treatment. However, you have rights under federal law and, in many cases, state law. Understanding the type of health insurance that you have, knowing what can be appealed, and following the right steps can meaningfully change the outcome.

Part II of this toolkit provides state-specific information about the appeals process where you live, including any additional protections your state offers. If you have a self-funded employer-sponsored health plan, keep in mind that most state-specific protections will not apply to your plan.

Part III of this toolkit includes forms and templates to help you get started.

You do not have to navigate health insurance alone. The Legal & Financial Navigation Program (TriageCancer.org/GetHealp) offers free one-on-one assistance, and the Triage Health Appeals Navigator (TriageCancer.org/Triage-Health-Appeals-Navigator) can help you build a personalized appeal letter based on your specific situation. Additional information on navigating health insurance can be found at: TriageCancer.org/HealthInsurance.

Glossary

These are common terms related to health insurance.

- **Monthly Premium**: what you pay each month to have health insurance coverage. You pay these costs even if you never get medical care.
- **Annual Deductible**: the amount you must pay out-of-pocket each year, before your health insurance policy kicks in.
- **Co-payment**: a fixed dollar amount you pay each time you get certain types of medical care (e.g., office visits)
- **Co-insurance**: also known as cost-share; a percentage difference between what the health insurer pays for your medical expenses and what you pay.
- **Out-of-pocket Maximum**: a fixed dollar amount that represents the most you will have to pay for your covered medical expenses out of your own pocket. Once you reach your out-of-pocket maximum, your health insurer pays 100% of your covered medical expenses for the rest of the year. This out-of-pocket maximum can include co-payments, deductibles, co-insurance, and out-of-pocket prescription drug costs.
- **Allowed Amount**: also known as the contracted amount, this is the amount that a health care provider is allowed to charge for a service received by a patient. This is usually discounted by the health insurer for in-network services and the patient is not necessarily responsible for the whole amount.
- **Formulary**: a list of prescription medications that a health insurance plan covers, often organized by cost or coverage level.
- **Co-pay Accumulator**: a program used by some health insurers that prevents co-pay assistance from drug manufacturers or nonprofit organizations from counting toward your deductible or out-of-pocket maximum. This means you may reach your out-of-pocket maximum much more slowly than expected, or not at all, even though the assistance is covering your costs.
- **Co-pay Maximizer**: similar to a co-pay accumulator, a program used by some health plans that does not count manufacturer co-pay assistance toward your deductible or out-of-pocket maximum. Instead of applying the assistance until it runs out, a maximizer spreads the total assistance amount evenly across the plan year, which can still leave you responsible for higher out-of-pocket costs later in the year.
- **Alternative Funding Program (AFP)**: a program that some employers use, often through a third-party vendor, to remove certain high-cost specialty medications from their plan's formulary by classifying them as “non-essential.” This is referred to as a “carve out.” Patients are then directed to apply for drug manufacturer or nonprofit financial assistance, instead of having the medication covered by insurance. Warning signs that your plan may be using an AFP include being told you must enroll in a separate program to access a medication, being told you cannot appeal a coverage denial, or being asked to sign a consent form allowing a third party to apply for financial assistance for you. Some examples of AFP vendors include Archimedes, SaveOnSP, and PrudentRx.
- **Brand-name Drug**: a prescription drug with a specific name from the company that sells the drug. A generic version of a drug may be available and sold by other companies, usually after a patent expires.
- **Generic Drug**: a prescription drug that contains the same chemical substance as a brand-name drug.
- **Specialty Drug**: prescription drugs that have a high cost, high complexity and/or require a high touch (e.g., they may need special handling or storage, be given by injection or infusion, or require close monitoring by your health care team). Many drugs for cancer, including many oral chemotherapy drugs, are considered specialty drugs.
- **Tiers**: cost levels within a formulary. A drug on a higher tier will have higher out-of-pocket costs for you. The highest tier in most formularies is the “specialty” tier, which includes many cancer drugs.

- **Step Therapy**: when an insurance company requires patients to try a generic or lower cost drug before getting a brand-name or more expensive drug. If the lower cost drug doesn't work or causes a bad reaction, the patient would be allowed to "step up" to another medication.
- **Exception Request**: an appeal based on medical necessity, asking your plan to cover a drug it would not normally cover. There are different types of exception requests: a non-formulary drug exception (ask to cover a non-formulary drug), a tier exception (ask to treat a drug as if it were in a lower tier, reducing your out-of-pocket costs), and a brand exception (ask to cover a higher-cost brand name drug even if a generic is available).
- **Specialty Pharmacy**: a pharmacy that provides specialty drugs. Specialty pharmacies often deliver medications by mail and may offer extra support, such as help managing side effects, instructions for handling and storing your medication, or help finding financial assistance. Your health insurer may require you to fill specialty drugs through a specific specialty pharmacy, so it is important to ask which pharmacy you need to use.
- **Mail-order Pharmacy**: some retail pharmacies also provide mail-order benefits, where you get your prescriptions in the mail. Some health plans require you to get your prescription through a mail-order service if it is an ongoing prescription.
- **Explanation of Benefits (EOB)**: a statement from your health insurer that details the claim received, how much the provider charged for the particular service (e.g., an X-ray), what the health insurer is going to pay the provider, and what you may owe the provider (often called the "patient responsibility"). Generally, EOBs are identified by the statement "THIS IS NOT A BILL" somewhere on the page.
- **Summary Plan Description (SPD)**: a document that explains how an employer-sponsored health plan works, including what it covers and how to file an appeal. Under ERISA, your employer must give you a copy of the SPD within 30 days of your request.
- **Employee Retirement Income Security Act (ERISA)**: a federal law that sets rules for most employer-sponsored health plans, including how claims and appeals must be handled.
- **Independent Review Organization (IRO)**: an organization that is not connected to your health insurer and that reviews and decides external appeals.
- **Claim File**: the complete record that your health insurer used to decide your claim. You have the right to request a copy of your claim file for free.

If you are looking for more information about these health insurance terms, visit: TriageCancer.org/HealthInsurance.

Appeals Checklist: Get Prepared

Use this checklist to make sure you have everything you need before submitting your appeal.

Understanding Your Plan

- ☐ I know what type of health insurance plan I have
- ☐ I know the steps I have to take to file an internal and external appeal (if needed)
- ☐ I have a copy of my Summary Plan Description (SPD) or Evidence of Coverage document
- ☐ I know if my state has additional protections that apply to my plan
- ☐ I know if my plan is self-funded and that most state protections do not apply to me

Getting Help

- ☐ I have talked to my health care team about whether they will file the appeal for me, or if I need to file the appeal
- ☐ I have considered whether to appoint an authorized representative
- ☐ I know how to reach my state insurance agency or other resources if I need help during the process

Understanding Your Denial

- ☐ I have received a written explanation of the denial
- ☐ I know the specific reason my claim was denied
- ☐ I know the specific plan provision my health insurer used to deny my care
- ☐ I know my deadline to file an appeal
- ☐ I have put the deadline in my calendar

Building Your Case

- ☐ I have requested my complete claim file from my health insurer
- ☐ I have reviewed my health insurer's medical policy or coverage guidelines for the denied care
- ☐ I have my up-to-date medical records related to the denied service
- ☐ I have a letter of medical necessity from my health care provider explaining why the care is medically necessary
- ☐ I have gathered relevant information, including test results, lab reports, imaging, or other clinical documentation
- ☐ I have researched clinical guidelines or medical literature supporting my treatment (e.g., NCCN guidelines)
- ☐ I have written a brief personal statement describing why I need the care that has been denied
- ☐ I have identified the specific reason I disagree with the denial

Submitting Your Appeal

- ☐ I have completed all required forms for my health insurer's appeals process
- ☐ I have included all required information (member name and ID, provider name, dates of service, claim reference number)
- ☐ I have made physical or electronic copies of everything I am submitting
- ☐ I am sending the information in a way that provides confirmation of receipt (certified mail for a physical file; screenshot or confirmation email for electronic file)
- ☐ I have recorded the date I submitted my appeal in my Appeals Tracking Form
- ☐ I have added the date that I should hear back from my health insurer in my calendar

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Triage Health State-Specific Appeals Toolkit: Part II

Georgia

Who This Section Covers

This section explains the Georgia-specific rules for appealing a denial from an individual health insurance plan or a funded employer-sponsored health plan. Use it along with Part I of this toolkit, which explains how internal and external appeals work.

Not sure what type of plan you have? See What Type of Health Insurance Do You Have? in Part I. If you have a self-funded employer plan, follow Part I, since Georgia insurance law generally does not apply. If you have coverage through the State Health Benefit Plan (SHBP), see Georgia Public Employee Plans below.

Georgia at a Glance

Who Regulates Your Plan: The Georgia Office of Commissioner of Insurance (OCI) regulates health insurers and HMOs.

State Term for an Internal Appeal: Managed care plans (e.g., HMOs, PPOs) call it a "grievance."

External Appeals: Most plans use the federal process (see Part I). Some managed care plans use Georgia's own process.

Deadline to Request an External Appeal: Generally, 4 months after you receive your final denial.

Cost: External appeals are free.

Consumer Assistance Program: Georgia does not currently have one, but OCI can help.

Questions About Your Rights: OCI Consumer Services, 1-800-656-2298.

Before You Start: What to Gather

- **Your Denial Letter:** Note the date you received it. Your deadlines start then.
- **Your Evidence of Coverage or Plan Documents:** These explain what your plan covers and how to file a grievance.
- **Your Claim File:** Ask your health insurer for a free copy of the records it used.
- **A Letter From Your Provider:** Explaining why the care is medically necessary.
- **Your Medical Records:** Include records that support your provider's letter.
- **The Appeals Tracking Form:** Use it to keep track of dates, calls, and documents. It is in Part III.

Georgia: Your Appeal, Step by Step

For individual plans and funded employer plans. Follow the arrows from the top.

1. You Received a Denial

Read your denial letter carefully and note the date you received it. Talk with your health care team about whether your situation is urgent.

Is your situation urgent?

No

2. File an Internal Appeal

Send a written grievance to your health insurer, following the instructions in your denial letter. If you have a managed care plan, you can ask for a hearing before a panel. Check your denial letter for your deadline.

File within: 180 days of receiving the denial

3. Internal Appeal Decision

Your health insurer must decide within 30 days if you have not received the care yet, or 60 days if you already received it.

Was it approved?

Yes → Your care is covered.

No, or no decision on time

4. Request an External Appeal

Send your request to the external review contact in your final denial letter. For most plans, this is Maximus Federal Services or an IRO chosen by your health insurer. If your letter says to send it to OCI, follow those instructions. Maximus: 1-888-975-1080

File within: 4 months of the final denial

5. External Appeal Decision

The reviewer must decide within 45 days. The decision is binding on your health insurer.

Yes

Urgent Appeal

When Your Situation Is Urgent

Urgent appeals are for care you have not received yet, or are in the middle of receiving. If your doctor says your situation is urgent, your health insurer must generally treat it as urgent.

What to Do

Ask your health insurer for an expedited internal appeal. You can usually ask by phone. At the same time, you can also request an expedited external appeal, so you do not have to wait for the internal decision.

Each decision within 72 hours

Decision

Key Contacts

Your health insurer
Number on your card or denial letter

Maximus (external appeals)
1-888-975-1080

GA Office of Commissioner of Insurance
1-800-656-2298

Free legal help
GeorgiaLegalAid.org

Denial Reversed

Your health insurer must cover your care.

Denial Upheld

You may be able to file a complaint with the Georgia Office of Commissioner of Insurance or get legal help.

Timelines are the maximums allowed under federal and Georgia rules for most individual and funded plans. Some plans, such as grandfathered plans, short-term plans, and government or church plans, may follow different rules. Check your denial letter and plan documents, and see the Georgia section for details.

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Internal Appeals in Georgia

Federal rules set the minimum requirements for internal appeals in Georgia (see Part I). When a Georgia rule gives you less time or fewer protections than federal rules, your health insurer must follow the federal rule. When a Georgia rule is more protective, your health insurer must follow the Georgia rule.

Managed Care Plans

Georgia law requires managed care plans (e.g., HMOs, PPOs) to have a grievance process for reviewing denials of care, and to explain it in your plan documents.[1]

If your grievance is about a denial of care, you have the right to a hearing before a panel of at least three people. At least one must be a physician other than the plan's medical director, and at least one must be a health care provider trained and licensed in the treatment that was denied. If the panel decides against you, the written notice must include its specific findings, the policies it relied on, and your providers' recommendations.[2]

Your health insurer must decide your grievance within 30 days if you have not received the care yet, or 60 days if you already received it. For urgent situations, the deadline is 72 hours.[3] These match the federal timelines.

Georgia rules also give you the right to a second review of a medical necessity denial. If you ask, a different health care provider in an appropriate medical specialty must review the decision.[4] This review is part of your internal appeal, so it does not replace your right to an external appeal.

Other Plan Types

If you have a plan that is not a managed care plan, your health insurer must follow the federal rules described in Part I. Your denial letter and plan documents should explain how to file.

External Appeals in Georgia

Georgia does not have its own external review process that meets federal standards. Instead, external appeals in Georgia go through one of the two federal processes described in The Federal External Review Process in Part I. Your health insurer decides which process applies, and your final denial letter should tell you where to send your request.

If your appeal goes to the HHS-Administered Federal External Review Process, contact Maximus Federal Services:

- **Online:** ExternalAppeal.CMS.gov
- **By Mail:** Maximus Federal Services, State Appeals East, 3750 Monroe Avenue, Suite 708, Pittsford, NY 14534
- **By Fax:** 1-888-866-6190
- **By Email:** ferp@maximus.com
- **By Phone:** 1-888-975-1080

The request form and the Appointment of Representative form are included in Part III.

Georgia's Independent Review Process

Georgia also has its own independent review law for some managed care plans, run by OCI.[5] For most plans, the federal process applies instead. Follow the instructions on your grievance decision letter on

[1] O.C.G.A. § 33-20A-5.
[2] O.C.G.A. § 33-20A-5(3)(B)(ii).
[3] Ga. Comp. R. & Regs. 120-2-111-.04(2).
[4] Ga. Comp. R. & Regs. 120-2-58-.05(6)(b).

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where to file. Plans that use the Georgia process must say so in bold type and include OCI's request forms.[6] The denied service must cost at least $500 to qualify for a Georgia review.[7] (The federal process has no minimum.) In a Georgia review, your health insurer has the burden of proving its decision was right.[8] The Georgia process also covers some experimental treatment denials for people with a terminal condition.[9] If you are not sure which process applies, call OCI at 1-800-656-2298.

Other Georgia Protections

Prior Authorization

Georgia law requires your health insurer, or any company that reviews prior authorization requests for it, to tell your provider about a prior authorization decision within 7 calendar days after it has all the information it needs. For urgent care, the deadline is 72 hours.[10] For the latest information, see Triage Cancer's chart of state prior authorization laws (TriageCancer.org/State-Laws/Health-Insurance-Prior-Authorization).

Georgia law also limits when a health insurer can take back an approval. If you get the approved care within 45 business days, your health insurer generally cannot revoke or limit the approval, except in cases such as fraud, a billing error, or loss of coverage.[11] If you switch to a new plan, your new health insurer must honor a prior authorization from your old plan for at least the first 30 days of coverage.[12]

Step Therapy

If you have stage four advanced metastatic cancer, your health insurer cannot require you to fail a different drug first, or prove you failed one before, to cover an FDA-approved drug. This applies when the use of the drug is consistent with best practices for treating stage four advanced metastatic cancer and is supported by peer-reviewed medical literature.[13] The law also applies to the state employee health plan.[14]

Reviewer Qualifications

If you have a managed care plan, the panel that hears your grievance must include a health care provider trained and licensed in the treatment that was denied (see Managed Care Plans above).[15]

Before your health insurer, or a company they hire to review claims, denies care as not medically necessary, your provider must have the chance to discuss the decision by phone with a clinical peer.[16] A clinical peer is a provider who has an unrestricted license, is in active practice in the same or a similar specialty as your provider, typically manages your condition, and has experience providing the treatment under review.[17]

In Georgia's independent review process, the expert reviewer must be an expert in treating your condition, with actual clinical experience with the recommended treatment. Physician reviewers must hold an unrestricted license and current board certification in an appropriate specialty, and reviewers cannot have a history of discipline.[18] If you think a reviewer did not have the right expertise, see Check the Reviewer's Qualifications in Part I.

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[5] O.C.G.A. §§ 33-20A-30 to 33-20A-42; Ga. Comp. R. & Regs. 120-2-111.
[6] Ga. Comp. R. & Regs. 120-2-111-.05(1).
[7] O.C.G.A. § 33-20A-33.
[8] Ga. Comp. R. & Regs. 120-2-111-.03(15)(d).
[9] Ga. Comp. R. & Regs. 120-2-111-.04(1)(b).
[10] O.C.G.A. §§ 33-46-26, 33-46-27.
[11] O.C.G.A. § 33-46-23.
[12] O.C.G.A. § 33-46-28.
[13] O.C.G.A. § 33-24-59.20(b).
[14] O.C.G.A. § 33-24-59.20(a)(1).
[15] O.C.G.A. § 33-20A-5(3)(B)(ii).
[16] Ga. Comp. R. & Regs. 120-2-58-.05(6)(a).
[17] Ga. Comp. R. & Regs. 120-2-58-.02(7).
[18] Ga. Comp. R. & Regs. 120-2-111-.03(6).

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Use of Artificial Intelligence (AI) in Prior Authorization

Starting January 1, 2027, Georgia law allows health insurers to use AI in reviewing requests for care, but AI cannot issue a denial on its own. Before a denial is issued, a qualified person must review the request with a clinical peer (a health care provider with relevant expertise), and AI cannot override that clinical peer's judgment.[19]

Medical Necessity Definition

Georgia law defines medically necessary care for independent reviews of managed care plan decisions. The care must be based on generally accepted medical practices and must be:[20]

- appropriate for your diagnosis, where going without it could harm your condition or keep it from improving;
- consistent with accepted medical practice in the United States;
- provided in a safe and appropriate setting for your diagnosis and symptoms;
- not provided only for your convenience or your provider's; and
- not mainly custodial care, unless your plan covers custodial care.

Even if your appeal goes through the federal process, you or your health care provider can point to this definition in your appeal.

Co-pay Accumulators

Georgia law requires pharmacy benefit managers to count co-pay assistance (e.g., a manufacturer co-pay card) toward your deductible and out-of-pocket maximum for a drug that does not have a generic equivalent. The same rule applies to a drug that has a generic equivalent if you got access to the brand-name drug through prior authorization, step therapy, or your health insurer's exceptions and appeals process.[21] For the latest information, see Triage Cancer's chart of state co-pay accumulator laws (TriageCancer.org/State-Laws/Co-Pay-Accumulators).

Note: This rule does not apply to group HMOs that have an exclusive contract with one medical group and run their own pharmacies.

Biomarker Testing

Georgia law requires health plans to cover biomarker testing to diagnose, treat, manage, or monitor a disease or condition, when the testing is supported by medical and scientific evidence (e.g., FDA approval, a Medicare coverage decision, or nationally recognized clinical practice guidelines). Coverage must be provided in a way that limits the need for extra biopsies. If prior authorization is required, your health insurer must decide within 7 calendar days, or 72 hours for urgent requests. If it does not respond on time, the request is treated as approved.[22] For the latest information, see Triage Cancer's chart of state biomarker testing laws (TriageCancer.org/State-Laws/Health-Insurance-Biomarker-Testing).

Fertility Preservation

For plans issued or renewed on or after January 1, 2026, Georgia law requires health plans to cover standard fertility preservation services when medically necessary treatment for cancer, sickle cell disease, or lupus may cause infertility. Covered services include egg, sperm, embryo, and ovarian tissue freezing, related evaluations, lab tests, and medications, and storage for one year. Plans may apply the same deductibles and co-pays as other services, and some limits, such as age limits.[23] For the latest

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[19] O.C.G.A. § 33-46-7.1 (eff. Jan. 1, 2027).
[20] O.C.G.A. § 33-20A-31; Ga. Comp. R. & Regs. 120-2-111-.02(22).
[21] O.C.G.A. § 33-64-10(e).
[22] O.C.G.A. § 33-24-59.33.
[23] O.C.G.A. § 33-24-59.34

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information, see Triage Cancer's chart of state fertility laws (TriageCancer.org/State-Laws/Health-Insurance-Fertility-Services).

Georgia Public Employee Plans

The State Health Benefit Plan (SHBP) covers state employees, public school employees, and retirees. Most SHBP plan options are self-funded, but the Kaiser Permanente HMO and the Medicare Advantage options are fully insured. SHBP has handed off medical appeals to its claims administrators (Anthem, Kaiser Permanente, and UnitedHealthcare) and pharmacy appeals to CVS Caremark. Follow the appeal instructions in your denial letter and plan booklet. For questions about eligibility or enrollment, contact SHBP Member Services at 1-800-610-1863.

Georgia's biomarker testing law also applies to coverage provided by the state.[24]

Filing a Regulatory Complaint

If you believe your health insurer is not following the rules, you can file a complaint with OCI. A complaint is not part of the appeals process and cannot, by itself, reverse a coverage decision. But OCI can review whether your health insurer followed Georgia law. If you have an HMO, OCI can also send your complaint to the HMO, which must respond in writing within 10 days.[25] OCI cannot help with self-funded employer plans.

- **Online:** oci.georgia.gov/how-do-i-file-complaint
- **By Phone:** 1-800-656-2298

Getting Help in Georgia

- **Georgia Office of Commissioner of Insurance and Safety Fire:** The Consumer Services Division can answer questions about your rights and help with problems with your health insurer. Call 1-800-656-2298.
- **Consumer Assistance Program:** As of October 2026, Georgia does not have a separate Consumer Assistance Program. OCI's Consumer Services Division continues to help consumers.
- **Legal Aid:** Search for free legal help near you at GeorgiaLegalAid.org.
- **Atlanta Bar Association Lawyer Referral and Information Service:** Can connect you with a lawyer for a low-cost first consultation. Call 404-521-0777.

[24] O.C.G.A. §§ 33-24-59.33
[25] Ga. Comp. R. & Regs. 120-2-33-.09(4)

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TRIAGE CANCER®

TRIAGE HEALTH

Part III

Forms

Forms and templates to help you file and track your appeal

TRIAGE CANCER® | TRIAGE HEALTH

Health Insurance Appeals Tracking Form

Fill in these boxes first, then log every step on the pages that follow. Keep copies of everything you send and receive.

1. About my claim

Insurance company name _____ **Policy or member number** _____ **Group number** _____

Procedure, service, or medication _____ **Claim or reference number** _____ **Date of service or request** _____

Reason for denial (copy from the denial letter) _____

Claim is for ☐ Prior authorization ☐ Benefits already received

Plan type ☐ Employer plan ☐ Self-insured employer plan ☐ Marketplace ☐ Medicare ☐ Medicaid

This form covers the general appeal process for private health plans. Medicare and Medicaid have different steps and timelines.

2. My plan's deadlines

Your denial letter and plan documents control these dates

Date on my denial notice _____
Every deadline counts from this date.

Deadline to file my internal appeal _____
Generally 180 days for many private plans.

Plan must decide my internal appeal by _____
Generally 30 days before care, 60 days after.

Deadline to request external review _____
Generally 4 months after the final denial.

Second appeal required? ☐ Yes ☐ No ☐ Not sure **Deadline** _____

☐ Expedited (urgent) review needed. Plans generally decide within 72 hours.

Find your state's rules
Scan to open Triage Cancer's State Specific Health Insurance Appeals Toolkit.
triagecancer.org/appealstoolkit

Health Insurance Appeals Tracking Form

Action	Date	Contact person	Method of contact and confirmation or tracking number	Expected response date	My deadline	Notes
Stage 1: initial claim or prior authorization request						
Sent my claim or prior authorization request						
Received my plan's decision						☐ Approved ☐ Denied ☐ Partly approved
If denied, asked my plan in writing for the full reason and my claim file						
Received the denial reason and claim file						
Asked my provider about a letter of medical necessity and a peer-to-peer review						
Received the letter and other supporting documents						

Peer-to-peer review: *Some plans let your doctor talk directly with the plan's doctor about a denial. Ask your plan if this is an option.*

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Health Insurance Appeals Tracking Form

Action	Date	Contact person	Method of contact and confirmation or tracking number	Expected response date	My deadline	Notes
Stage 2: internal appeal						
Filed my internal appeal						
Received my plan's decision on my internal appeal						☐ Approved ☐ Denied ☐ Partly approved
Asked my plan for the evidence and reasons behind its decision						
Received the evidence and reasons						
Filed my second internal appeal (only if my plan or state requires it)						
Received my plan's decision on my second internal appeal						☐ Approved ☐ Denied ☐ Partly approved

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Health Insurance Appeals Tracking Form

Action	Date	Contact person	Method of contact and confirmation or tracking number	Expected response date	My deadline	Notes
Stage 3: external review						
Asked my provider for any new supporting documents						
Received the new documents						
Filed my external review request						
Received the external reviewer's decision						☐ Approved ☐ Denied ☐ Partly approved
Any stage: free help						
Contacted my state insurance department or consumer assistance program						

Health Insurance Appeals Tracking Form

Final outcome and next steps

Where my appeal ended up ☐ Approved ☐ Partly approved ☐ Denied ☐ Still waiting

What happens next (for example: another appeal level, a state complaint, or help finding other coverage)

More notes

Calls, names, reference numbers, and questions for my health care team

This chart is a general process and method of tracking for your insurance appeal. Learn more about appeals and the rules in your state at triagecancer.org/appealstoolkit or HealthCare.gov (search "appeals"). If you have a self-insured employer-sponsored health plan, contact the Employee Benefits Security Administration, U.S. Department of Labor, at askebsa.dol.gov or 866-444-3272.

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How to use these letters

Use these samples for an internal appeal. You can also attach one to an external review request.

- Replace everything in [brackets] with your own details, and delete any line that does not apply.
- Keep the letter to one page if you can. Stick to the facts that show why the care is needed.
- Enclose your denial letter and a letter from your doctor or health care provider explaining why the care is medically necessary.
- Check your denial letter for the deadline and the address or fax number, and send your appeal well before the deadline.
- Send it in a way that gives you proof of delivery (e.g., certified mail, a fax confirmation, or your health insurer’s online portal), and keep a copy.
- If waiting could seriously harm your health, ask your doctor to say so in writing, and ask for an expedited (urgent) appeal.
- Your state may give you more protections. See your state’s section in Part II.

Sample letter 1: prescription drug denied

[Date]

[Health insurer name]
Appeals Department
[Address or fax number from your denial letter]

Re: Internal appeal of denial for [drug name]
Member name: [Your name]
Member ID: [ID number]
Claim or reference number: [Number from denial letter]
Date of denial letter: [Date]

To the appeals reviewer:

I am appealing the denial of [drug name], which my doctor, [doctor's name], prescribed to treat my [diagnosis]. Your letter says the drug was denied because [reason stated in denial letter, such as "I have not tried and failed other medications first"]. I am asking you to reverse this decision.

[If your doctor says waiting could seriously harm your health: I am requesting an expedited (urgent) internal appeal. A statement from my doctor is enclosed.]

I was diagnosed with [diagnosis] on [date]. Since then, I have been treated with [list prior treatments, with dates if possible]. [Briefly explain what happened with each one, such as "The first drug stopped working after four months" or "I had to stop the second drug because of severe side effects, including ___."] My doctor believes [drug name] is the right next step because [one or two plain sentences from the doctor's reasoning, if known].

[Drug name] is FDA-approved for, or recommended in the National Comprehensive Cancer Network (NCCN) guidelines for, [diagnosis]. [Name the source if you have it, such as the FDA label or the NCCN guideline, and enclose a copy.] [If the drug is called experimental or investigational: explain that standard treatments have not worked or are not right for you, and enclose published studies or guidelines that support the treatment.] [If your state has a law that applies, such as a limit on step therapy or a prior authorization deadline, name the law here. See your state's section in Part II.]

Waiting or trying another drug first may harm my health. [Describe the real effect, such as "My doctor has told me that my cancer may grow or spread if we delay" or "Every week without treatment, my symptoms get worse."] It is also affecting my daily life. [Give one or two specific examples, such as "I have missed [number] weeks of work," "I can no longer care for my children on my own," or "I have been in the hospital [number] times since this treatment was stopped."]

I am asking you to approve coverage for [drug name] as prescribed. Please send me, free of charge, a copy of my full claim file now, including the clinical criteria used to make the decision and the name and credentials of the reviewer. Please have my appeal reviewed by someone who was not involved in the first decision and who has experience treating [type of cancer or condition].

Thank you for your time and attention to my appeal.

Sincerely,
[Name]
[Phone number and email]

Enclosures: Denial letter, letter from Dr. [name] explaining why [drug name] is medically necessary, [other records, such as pathology report or treatment history]

Sample letter 2: procedure or service denied as not medically necessary

[Date]

[Health insurer name]
Appeals Department
[Address or fax number from your denial letter]

Re: Internal appeal of denial for [procedure, test, or service]
Member name: [Your name]
Member ID: [ID number]
Claim or reference number: [Number from denial letter]
Date of denial letter: [Date]

To the appeals reviewer:

I am appealing your decision to deny [procedure, test, or service]. Your denial letter states that it is "not medically necessary" because [reason stated in the letter]. My care team disagrees, and so do I.

[If your doctor says waiting could seriously harm your health: I am requesting an expedited (urgent) internal appeal. A statement from my doctor is enclosed.]

In [month and year], I was diagnosed with [diagnosis]. My doctor, [doctor's name], recommended [procedure, test, or service] on [date] because [plain explanation, such as "it will show whether my cancer has spread" or "it is the best way to remove the tumor safely"]. [If relevant: "My doctor has explained that other options may be less effective or riskier for someone with my history of ___."]

[Name the guideline if you know it, such as "NCCN or ASCO guidelines recommend this for my diagnosis," and enclose a copy.] [If you already received the care: ask your health insurer to pay the claim, and list the date or dates of service.] [If the care is called experimental or investigational: explain that standard treatments have not worked or are not right for you, and enclose published studies or guidelines that support it.] [If your state has a law that applies, such as a limit on step therapy or a prior authorization deadline, name the law here. See your state's section in Part II.]

This denial has already caused harm. [Describe the specific impact, such as "My surgery was scheduled for [date] and had to be canceled," "I have been waiting [number] weeks without a treatment plan," or "I am paying out-of-pocket for appointments I cannot afford."] I am also dealing with [emotional, financial, or family impact, in one or two honest sentences].

I am asking you to reverse this decision and approve [procedure, test, or service] as soon as possible. [If timing matters: Because my doctor believes a delay could affect my outcome, please decide this appeal as quickly as you can.]

Please send me, free of charge, a copy of my full claim file now, including the clinical guidelines used to review my case. Please have my appeal reviewed by someone who was not involved in the first decision and who has experience treating [type of cancer or condition].

Sincerely,
[Name]
[Phone number and email]

Enclosures: Denial letter, letter from Dr. [name] explaining why [procedure, test, or service] is medically necessary, [supporting records, such as imaging reports or clinical notes]

Sample letter 3: caregiver writing on behalf of a loved one

[Date]

[Health insurer name]
Appeals Department
[Address or fax number from your denial letter]

Re: Urgent internal appeal for [patient's name]
Member name: [Patient's name]
Member ID: [ID number]
Claim or reference number: [Number from denial letter]
Date of denial letter: [Date]

To the appeals reviewer:

I am writing on behalf of my [relationship, such as spouse, mother, or son], [patient's name], who has [diagnosis]. [Patient's name] has given me permission to act as their representative, and the signed [Appointment of Representative form or your health insurer's authorization form] is enclosed. [If the patient cannot sign: I am [patient's name]'s legal guardian or health care agent, and the documentation is enclosed.] We are appealing the denial of [drug, procedure, or service] and asking for an expedited (urgent) internal appeal.

[Patient's name] is [age] and was diagnosed with [diagnosis] in [month and year]. [Describe treatment so far in two or three sentences.] Dr. [name] has recommended [drug, procedure, or service] because [plain explanation]. Your letter says it was denied because [reason from denial letter]. [Add one line on the medical support, such as "This treatment is FDA-approved for, or recommended in NCCN guidelines for, [diagnosis]."] [If your state has a law that applies, such as a limit on step therapy or a prior authorization deadline, name the law here. See your state's section in Part II.]

Our family is facing a serious situation. [Patient's name] [describe current condition, such as "is losing strength each week" or "cannot start the next phase of treatment until this is approved"]. I have [describe caregiver impact, such as "taken unpaid leave from my job" or "been driving [number] hours each week to appointments"]. We are worried that any further delay could make it harder for [patient's name] to recover.

We are asking you to approve [drug, procedure, or service] as prescribed. Because Dr. [name] believes a delay may seriously affect [patient's name]'s health, please handle this appeal on an expedited basis. Please send me, free of charge, a copy of [patient's name]'s full claim file now, including the clinical criteria used to make the decision. Please have the appeal reviewed by someone who was not involved in the first decision and who has experience treating [type of cancer or condition]. You can reach me at [phone number] at any time.

Sincerely,
[Your name]
[Relationship to patient]
[Phone number and email]

Enclosures: Denial letter, signed [Appointment of Representative form or health insurer's authorization form], statement from Dr. [name] that a delay may seriously harm [patient's name]'s health, letter from Dr. [name] explaining why the care is medically necessary, [supporting records]

MAXIMUS Federal Services

HHS-Administered Federal External Review Request Form

In most cases, you must complete the mandatory internal appeal offered by your health plan or insurance issuer before we can begin an external review. Additionally, we must receive this completed form within four months of the date your plan or insurer sent you a final decision denying your services or your claim for payment.

Medical Necessity Reviews

Any health plan or insurance issuer denials associated with medical necessity, appropriateness, health care setting, and level of care, effectiveness of a covered benefit, experimental/investigational treatment, and any other matters involving medical judgment.

Rescission Reviews

A decision by a health plan or health issuer to retroactively cancel (back to an earlier date) or discontinue a policyholder's coverage.

No Surprises Act Reviews:

Health plan or insurance issuer denials or decisions associated with claim processing and payment issues, such as: (1) patient cost sharing protections for emergency services; (2) patient cost sharing protections related to care provided by nonparticipating providers at participating facilities; (3) whether patients are in a condition to receive notice and provide informed consent to waive No Surprises Act protections; and (4) whether a claim for care received is coded correctly and accurately reflects the treatment(s) received, and any related patient cost-sharing

Section 1: Covered person

This section is about the person who received or will receive the benefit or treatment.

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Please complete this section if you are the covered person's parent or legal guardian

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Section 2: Insurance company information

Please complete this section for each insurance company involved with your claim.

Insurance company #1:	Insurance plan or plan option *(if applicable):*
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Insurance company #2:	Insurance plan or plan option *(if applicable):*
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Section 3: Dispute Description

Please describe the reason(s) for the dispute.

Have you already received these medical services? Yes No

If so, when were the services received? *(Month, day, year)* _____

Please state the reason that you believe the Health Plan's decision was not correct.

Section 4: Claims for Urgent Care

If you believe your situation is urgent, you may ask for an expedited (fast) review.

An urgent care situation is one in which your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision.

To ask for an expedited external review:

Fax this form to 1-888-866-6190 OR Mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 708, Pittsford, NY 14534.

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant's condition. The medical professional will not be required to submit proof of authorization.

If you have questions about your external review, call: **1-888-975-1080** or email ferp@maximus.com.

Is this external review for urgent care? ☐Yes ☐No

Section 5: Claims involving a rescission of coverage

A **rescission** is an action by a health insurance issuer to retroactively cancel (back to an earlier date) or discontinue a policyholder's coverage.

Is this request for external review of a rescission of health insurance coverage? ☐Yes ☐No

Section 6: Additional information you may give

MAXIMUS Federal Services will use the information on this form to get the relevant information and documents from your insurer. You may add supporting information and documents you think the insurer may not be able to provide.

For example, you may choose to give us:

- Documents to support the claim, such as physicians' letters, reports, bills, medical records, and Explanation of Benefits (EOB) forms
- Letters you sent to your insurance plan or issuer about the claim
- Letters the plan or issuer sent to you about the claim

You do not have to give us this additional information. However, if you do not give us any additional information, MAXIMUS Federal Services may decide your case based only on the information your insurance issuer or plan gives us.

You can give MAXIMUS additional information for your external review by sending it with this form:

Fax to 1-888-866-6190 **OR** mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 708, Pittsford, NY 14534.

If you have questions about your external review, call **1-888-975-1080**.

Questions?	Call **1-888-975-1080** Monday – Friday 8:00am – 5:00pm EST

Sign the consent form.

Please sign and date the form.

Signature:_____ Date: _____

Printed name: _____

I am the: ☐ Covered person ☐ Parent or legal guardian ☐ Authorized Representative

NOTE: The covered person must sign this consent form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form. If the covered person cannot sign this form, the authorized representative must give written proof of his or her authority to sign. You may obtain the Authorized Representative form at https://externalappeal.cms.gov/ferpportal/#/forms

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Privacy Act Statement: The following website provides a notice of your rights under the Privacy Act and includes information about how the information on this form will be used and about our legal authority to collect this information: http://cciio.cms.gov/resources/other/index.html.

HHS Federal External Review Process
Appointment of Representative Form

Please return this signed and completed form to the following address:
HHS Federal External Review Process
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 708
Pittsford, NY 14534

Section 1: APPOINTMENT OF REPRESENTATIVE

NAME OF CLAIMANT	*PLAN|INSURANCE IDENTIFICATION NUMBER*

To be completed by the claimant:

I appoint this individual:_____ to act as my representative in connection with my request for external review by the HHS Federal External Review Process. I authorize this individual to make any request; to present or to produce evidence; to obtain external review information; and to receive any notice in connection with my external review, wholly in my place. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF CLAIMANT		*DATE*
STREET ADDRESS		*PHONE NUMBER*
CITY	*STATE*	*ZIP*

Section 2: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____ hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; and that I am not, as a current or former employee of the United States, disqualified from acting as the claimant's representative.

I am a / an _____
(Professional Status Or Relationship To The Claimant, E.G., Attorney, Relative, Etc.)

SIGNATURE OF REPRESENTATIVE		*DATE*
STREET ADDRESS		*PHONE NUMBER*
CITY	*STATE*	*ZIP*