Appendix B: Patient Request for Medical Necessity Criteria

Sample Facsimile/Email Request

[Date]

Via Facsimile – [Fax No#] (or Email)
[Insurance Company and/or Managed Behavioral Health Company] [Member Services Dept. or other applicable dept.]
[Address, if needed]

Dear [Member Services or other applicable dept.]:

My name is [insured patient's name] and I am insured under policy # [insert policy #] and group # [insert group #]. My plan is governed by the Federal Mental Health Parity and Addiction Equity Act.

I am currently a patient at [insert name of provider], and I hereby request a copy of the specific reason(s) for denial of the treatment services requested and of the specific medical necessity criteria that you are relying on in denying reimbursement for my treatment services. I am also requesting a copy of the medical/surgical "medical necessity" criteria for similar service categories and the plan's analysis of how the behavioral health criteria is comparable to and is applied no more stringently than the medical/surgical criteria for similar service categories:

- ❑❑ Detoxification
- ❑❑ Inpatient rehab
- ❑❑ Residential
- ❑❑ Partial hospitalization
- ❑❑ Intensive outpatient
- ❑❑ Outpatient
- ❑❑ Prescription drugs

I have paid for this benefit, and [insert name of provider] is licensed by the state of [insert state] [and nationally accredited, if applicable] to provide these treatment services. My attending physician has admitted me to this/these level(s) of care and is recommending my continued treatment. I am in dire need of these treatment services and they are covered by my benefit plan and should be paid for.

I request that you immediately fax this relevant information to me so that I may fully understand how you reached a different decision than my treating physician in refusing to cover my treatment services.

Please fax the above requested information to my attention at fax # [insert #]. If you would like to speak with me, please contact [insert name of applicable care provider contact].