Appendix C: Appeal Letter Samples

1: Denial Based on Freestanding or Residential Facility-Type Exclusions

Note: Highlights facility-related adverse determinations or denials.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

I have been a member of your plan since [date] and am now writing to appeal your decision to deny coverage for [state the name of the specific treatment or service denied AND if it is urgently needed to prevent harm or the inability to regain maximal function]. It is my understanding based on your letter dated [insert date of denial] that this [treatment or service] has been denied because: [Quote the specific reason given in the denial letter].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications. I have also attached a rationale for why I am entitled to this service under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). [If the treatment is urgent, then the treating professional should indicate so in the attached letter.]

I also hereby request that you: 1) provide me with a copy of the SBC and/or SPD and complete benefit plan booklet for both the medical/surgical and mental health/substance use disorder benefits within 30 days; 2) explain the specific plan provisions you are relying upon to exclude coverage for this facility type and the services they provide; 3) provide me with plan documents under which the plan is established or operated, with information on the processes, strategies, evidentiary standards and other factors used to exclude coverage for [freestanding or residential treatment facilities] under the behavioral health benefit; and 4) explain how that is comparable to and applied no more stringently than coverage or non-coverage for similar provider types under the medical/surgical benefit. Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure:
Clinical guidelines where appropriate

2: Denial Based on Level of Care Exclusions

Note: Highlights adverse determinations where care is categorically limited or denied.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

I have been a member of your plan since [date] and am now writing to appeal your decision to deny coverage for [state the name of the specific treatment or service denied AND if it is urgently needed to prevent harm or the inability to regain maximal function]. It is my understanding based on your letter dated [insert date of denial] that this [treatment or service] has been denied because: [Quote the specific reason given in the denial letter].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications. I have also attached a rationale for why I am entitled to this service under the

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
[If the treatment is urgent, then the treating professional should indicate so in the attached letter.]

I also hereby request that you: 1) provide me with a copy of the SBC and/or SPD and complete benefit plan booklet for both the medical/surgical and mental health/substance use disorder benefits within 30 days; 2) explain the specific plan provisions you are relying upon to exclude coverage of these services; 3) provide me with plan documents under which the plan is established or operated, with information on the processes, strategies, evidentiary standards and other factors used to exclude coverage for [indicate level of care] under the behavioral health benefit; and 4) explain how that is comparable to and applied no more stringently than coverage or non-coverage for similar services under the medical/surgical benefit. Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure:
Clinical Guidelines where appropriate

3: Denial Based on Blanket Exclusions of Office-Based Diagnostic and Treatment Interventions

Note: Highlights adverse determinations and denials related psychological testing for diagnostic assessments or other treatment services like individual psychotherapy and family counseling.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]

[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

I have been a member of your plan since [date] and am now writing to appeal your decision to deny coverage for [state the name of the specific treatment or service denied AND if it is urgently needed to prevent harm or the inability to regain maximal function]. It is my understanding based on your letter dated [insert date of denial] that this [treatment or service] has been denied because: [Quote the specific reason given in the denial letter].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications. I have also attached a rationale for why I am entitled to this service under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). [If the treatment is urgent, then the treating professional should indicate so in the attached letter.]

I also hereby request that you: 1) provide me with a copy of the SBC and/or SPD and complete benefit plan booklet for both the medical/surgical and mental health/substance use disorder benefits within 30 days; 2) explain the specific plan provisions you are relying upon to exclude coverage of these services; and 3) provide me with plan documents under which the plan is established or operated, with information on the processes, strategies, evidentiary standards and other factors used to exclude coverage for outpatient diagnostic services and treatment under the behavioral health benefit. Should you require

additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure: Clinical Guidelines where appropriate