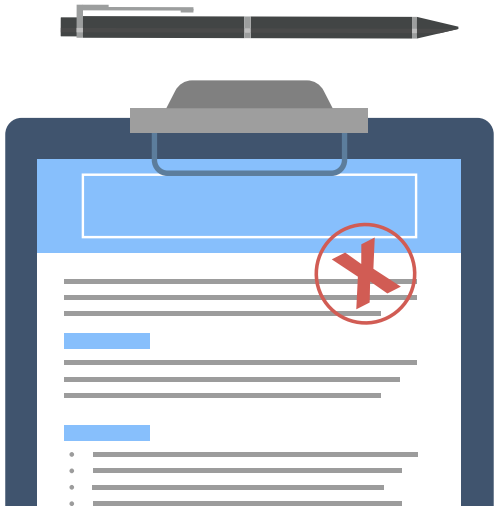
WHAT TO DO IF YOUR HEALTH INSURER DENIES YOUR CLAIM

If your insurance company denied your claim for migraine-related care, would you know what to do? You have a legal right to appeal the decision. There are steps and resources available to help you, and you should coordinate with your health care provider in the appeals process.

REASONS YOUR CLAIM MIGHT BE DENIED

- the benefit isn't offered under your health plan
- the requested service or treatment is deemed "not **medically necessary**"
- the requested service or treatment is considered "experimental" or "investigative"
- your medical problem began before you joined the plan
- the health care provider from whom you received care isn't in your plan's approved network
- the requested treatment is not on your plan's **formulary**



Society for Women's Health Research

YOU HAVE THE RIGHT TO APPEAL THE DECISION

Insurers are required to tell you how you can dispute their decisions and have them reviewed by a third party. If you decide to appeal, it's best to take action immediately. Read your insurance policy carefully to understand what it covers and outline your argument for why your insurer should honor your appeal.

CLAIM DENIAL NOTIFICATION

Your insurer must notify you in writing as to why it denied your claim and it must do so within specified timeframes based on the circumstance:

- For **prior authorization of a treatment,** your insurer must notify you within 15 days.
- For **medical services already received,** your insurer must notify you within 30 days.
- For **urgent care cases,** your insurer must notify you within 72 hours.

TO APPEAL, FOLLOW TWO STEPS... (SEE BACK)

STEP 1: FILE AN INTERNAL APPEAL

- Submit all forms required by your insurer and make copies for your records.
- Include any supplemental information that you want the insurer to consider, such as a letter from your health care provider.
- File within 180 days (6 months) of receiving notice of your claim denial.
- If the case is urgent, file sooner and ask your insurer to expedite the process.

Internal Appeal Documents

- **Explanation of Benefits** forms showing the denied services
- Internal appeal letter to your insurance company
- Letters from your doctor explaining medical necessity
- Notes from phone conversations with your insurer

WHAT TO EXPECT

Length of Process

If your appeal is for a service you have not yet received, your insurer must complete your appeal within 30 days. If your appeal is for a service you've already received, your insurer must complete your appeal within 60 days.

Written Notification

Your insurer must notify you in writing of its appeals decision. If the decision remains a denial, you can ask for an external review, and the insurance company's written notification must include guidance on how you can request one.

STEP 2: REQUEST AN EXTERNAL REVIEW

- Review the notice from your insurer and submit a written request within the required timeframe (generally 60 days from the date your insurer sent its final decision).
- You may appoint a representative who knows about your medical condition to file an external review on your behalf and who will need to complete an **authorized representative form.**

Types of Denials Subject to External Review

- Disagreements between you and your insurance company involving medical judgement
- Disagreements over whether treatments are "experimental" or "investigational"

WHAT TO EXPECT

Length of Process

Standard external reviews are completed no later than 60 days after the request was received.

Cost of an External Review

If your insurer has contracted with an independent review organization or uses a state external review process, you may be charged a fee. If so, the charge should not exceed $25 per external review. If your insurance company uses the process administered by the Department of Health and Human Services (HHS), there is no charge.

ADDITIONAL RESOURCES

EMPLOYER

If you receive health insurance coverage through your employer, contact the human resources department. Ask whether your company has dedicated case managers who can assist with your appeal and whether you're eligible to participate in a state-run external review process.

STATE

If you need help filing an internal appeal or external review, contact your state's **Consumer Assistance Program.** Many states fund independent ombudsman offices or offer administrative help with difficult claims.

FEDERAL

For help understanding employer-sponsored benefits, contact **The Employee Benefits Security Administration** within the U.S. Department of Labor.