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To apply for additional treatment access support, please visit www.theprojectheal.org/apply-for-support
Affordable Care Act (ACA): the name of the health care reform law finalized in March 2010 that allowed people to purchase their own insurance as individuals, regardless of pre-existing conditions.

Allowed Amount: the negotiated rate your insurance company and provider have agreed upon for a particular service when completed within your insurance network. Your co-payments and co-insurance will be based on this amount.

Annual Limit: the amount an insurance plan will pay in total benefits over a year. Once you hit the cap, your policy will not pay again until the next year. The ACA prohibits annual limits on essential health benefits with the exception of grandfathered plans.

Benefits: the healthcare items or services covered under a health insurance plan.

Co-Payment: the amount you pay when you receive care. The co-payment amount is set by the insurance company not the doctor's office. This can be a percentage or flat rate amount. For example, the amount you pay may be $30.00 each time with the insurance company picking up the rest of the cost.

Co-Insurance: the amount you pay after you meet the plan’s deductible. For example, an 80/20 co-insurance rate means the insurance company pays 80 percent and you pay the remaining 20 percent. Co-Insurance usually does not start until you pay an amount equal to the deductible.

Deductible: the amount you pay out-of-pocket for medical expenses before your plan pays anything for the healthcare services you received. For example, if your deductible is $1,000, your plan won’t pay their portion for a covered service until you’ve hit your $1,000 limit. Premiums do not count toward meeting your deductible.

Excluded Services: services your health insurance company or specific plan doesn’t pay for.

Exclusive Provider Organization (EPO) Plan: this plan is similar to a HMO plan in that members are required to use network doctors. However, unlike a HMO plan, it is not necessary to select a PCP, you do need to contact a PCP for specialist referrals.
**Explanation Of Benefits (EOB):** an EOB is created after a claim payment has been processed by your health care plan. It explains the actions taken on a claim such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process. EOBs are available both as a paper copy and online.

**Formulary or Drug List:** a list of prescription drugs your health plan covers. Generic medications are typically covered in a formulary, whereas only some brand names are not.

**Flexible Benefits Plan:** a benefit program that gives employees a choice between cash, life insurance, vacations, retirement plans, and childcare. Although there are usually some requirements, flexible benefit plans offer a choice for the remaining benefits.

**Health Insurance:** a contract that requires your health insurer to pay for a portion (or all) of your healthcare services in exchange for a premium.

**Health Insurance Marketplace:** website where individuals, families, and businesses based in the US can research, compare and choose a health insurance plan that’s best for them.

**Health Maintenance Organization (HMO) Plan:** in this plan, your Primary Care Provider (PCP) is who you want to reach out to first. If you need care outside of what your PCP can offer, they will refer you to another provider.

**In-Network or Preferred Provider:** a physician, healthcare provider or healthcare facility that has a contract with your plan to provide their members services at a lower cost to the insurance company.

**Medical Necessity Criteria:** standards used by health plans to decide whether treatments or health care supplies recommended by your mental health provider are reasonable, necessary and appropriate. If the health plan decides the treatment meets these standards then the requested care is considered medically necessary.

**Network:** the contract between your insurance and your healthcare provider.

**Out-of-Network:** a physician, healthcare provider or healthcare facility that does not have a contract with your plan. Using healthcare services that are not covered in your plan will greatly increase the amount you have to pay.
**Out-of-Pocket Limit:** the amount you pay out of your own pocket when treatment or service is not covered by your plan. For example, some plans do not cover laboratory tests, x-rays, or medication.

**Out-of-Pocket Maximum:** the highest amount of money a person will have to pay during their plan period. It includes the money spent within the deductible amount, co-insurance, co-pays. Once you reach this limit, the insurance company will pay 100% of the allowable amount of costs for all covered benefits. Out-of-pocket maximum is higher than your deductible and does not include medication costs or services that are listed as excluded within your plan language. Today most plans have separate medication and medical out-of-pocket maximums.

**Point of Service (POS) Plans:** this kind of plan will allow you to pay less if you use in-network doctors or services.

**Preauthorization (aka: prior-authorization or pre-approval):** an insurance plan may require prior approval for certain services, drugs, or equipment to consider any charges. Preauthorization is not a guarantee that the insurance plan will cover the cost of the service, however, this is generally the first step for those requiring services that are not currently in-network with their insurance plan.

**Preferred Provider Organization (PPO) Plan:** this plan provides the patient access to a network of preferred providers, also known as in-network doctors. This means the list of doctors have been approved by your health insurance plan. Your out-of-pocket expenses will be less if you use a provider within the plan, however if you use a doctor that is out of network, you will still receive some reimbursement. This type of plan is typically more expensive but they include a larger network of doctors, including specialty doctors.

**Premium:** the amount you pay monthly, quarterly or yearly for your health insurance plan. If you have insurance through the workplace, your employer may pay a portion of your premium on your behalf as part of your employee benefit package.

**Provider:** a physician, healthcare provider or healthcare facility licensed, certified or accredited as required by law.

**Specialist:** this type of provider focuses on a specific area of medicine or illness. Some specialists may not be in-network with your plan.
Utilization review (or utilization management): process used by insurers to decide whether the requested mental health care is medically necessary, efficient and in line with accepted medical practice. In line with accepted medical practice means that the mental health treatment or service is proven to be effective based on scientific evidence.

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Health insurance policies can be overwhelming and tricky. There is a lot of different information that varies by policy, and it can be confusing to understand what your plan does and does not cover, how much the cost is per service, etc.

**Q: What do all the different payment terms mean?**

**A:** A few different factors go into paying for treatment. Most insurance plans have a **premium**, which is a monthly fee that the patient pays for their insurance plan. Many patients also have an **insurance deductible**, which is a set amount that the patient has to pay out-of-pocket before their insurance benefits kick in. After the deductible is met, patients are typically responsible for a **copay** (a set dollar amount per visit) or **co-insurance** (a set percentage of the total cost of the visit) each time they receive treatment. Many insurance plans also have an **out-of-pocket maximum (OOPM)**, which is a cap on the amount that the patient pays per year in copays and/or co-insurance.

**Q: What are common reasons an insurance company denies coverage of eating disorder treatment or payment for services?**

**A:** While there are many reasons a health insurance plan may deny coverage of eating disorder treatment or payment for such services, there are some common reasons you may be experiencing, depending on your plan and the services you are seeking coverage for.

- Level of care (or services) deemed not “medically necessary”
- Not eligible for coverage of services requested under your health plan and/or lack of your plan including a benefit (such as eating disorder residential level of care)
- Failure to attempt treatment a lower level of care prior to requesting coverage for a higher level of care
- Not eligible for coverage of services requested until trying “X” services (generally preferred in-network option or one geographically closer)
- Eating disorders are not an explicitly named “row” of issues covered on your health plan’s Explanation of Benefits (EOB) and therefore quickly dismissed without adequate exploration by the payor
Q: What is the difference between Medicare and Medicaid?

A: Medicaid is a state-run health insurance for people whose income is below a certain level. Medicare is a federally-run health insurance for people above the age of 65 and who have certain qualifying disabilities. Medicaid coverage can vary by state and managed Medicaid plan, while Medicare is accepted in many states regardless of the plan.

Q: What ED treatment do Medicare and Medicaid cover, and why is it so limited?

A: Currently, most Medicare and Medicaid plans limit their coverage of eating disorder treatment to inpatient (hospital-based) and outpatient programs. It’s important, however, to keep in mind that every plan is different and that you should contact your insurance company to verify your benefits and coverage options.

The coverage of eating disorder treatment for those with Medicare and Medicaid is so limited because of how those programs have been designed. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally requires group health plans and health insurance payors to provide mental health or substance use disorder benefits to have equal benefit coverage of mental health diagnoses as medical diagnoses. However, because medical issues are treated either in a hospital or via office visits, the MHPAEA limits mental health coverage to the same treatment options, i.e. inpatient or outpatient. This then excludes any other levels of care that are often required for mental health conditions like eating disorders, including residential, most partial hospitalization programs (unless they are hospital-based), and most intensive outpatient programs (unless they are hospital-based).

Q: How do I know which providers are in-network?

A: In-network providers are those who are “preferred” or covered by your insurance plan. To find who is in your network, it may be easier to call your Member Services number and request a list to be emailed to you, listing in-network providers you are looking for (Therapist, dietitian, psychiatrist, etc.).
These providers may be available on the insurance website when entering your area code in a search tool, and if you are purchasing an insurance plan on the Insurance Marketplace, you can enter your providers in a tool to show which plans match your current providers. Another way to check if your providers take your specific plan is to call your selected provider’s office, and they will inform you if they are in- or out-of-network and provide a benefits check before your scheduled appointment.

**Q: My insurance plan does not have any in-network outpatient specialized eating disorder therapists. Is there anything I can do to avoid paying a provider out-of-pocket?**

**A:** Depending on the specific insurance plan, there are likely steps you can take to avoid taking on out-of-pocket costs. Specifically, you will want to follow up with a representative from your insurance company who can let you know whether or not your plan has an option to coordinate a single case agreement (SCA) or special coverage agreements. An SCA is a contract between an insurance company and an out-of-network health care provider for a specific patient that enables the patient to receive in-network coverage for an out-of-network provider for an established period of time. Calling the Member Services number, typically located on the back of your insurance card, will connect you to an insurance representative.

**Q: What do I need to do to see a provider out-of-network?**

**A:** If you do need to see a provider who is not in your network or, out-of-network, due to the services you are seeking not being available in-network or in your area, there are additional and different steps you may need to take per your plan’s out-of-network policy.

If your plan has an out-of-network benefit, this will likely be covered by the plan, but this will usually be at a higher deductible and/or co-pay. Often if out-of-network benefits are available, there may be a $4,000 deductible for in-network services, for example, and a $8,000 deductible for out-of-network. Your in-network copay may be $25 to see your PCP, whereas the out-of-network copay may be $50.

It is often the case that eating disorder providers or treatment centers will be out-of-network (a frequent and understandable frustration). Eating disorder providers may be out-of-network if your insurance plan does not cover eating disorder services, or there are no specialists available in your area or network.
In these cases, if it is an outpatient provider you are seeking for an eating disorder and they are out-of-network, this will often have to be paid out-of-pocket. Many outpatient providers offer a sliding scale, and you may be able to discuss with them a smaller amount they are willing to bill for your sessions. If an eating disorder treatment center is out-of-network, many plans will allow a Single Case Agreement, a one-time, negotiated contract between provider and insurance payor to set up coverage for your treatment. The amount billed and paid for this service will be discussed ahead of time.

Q: What is pre-authorization and utilization review?

A: A pre-authorization review occurs when your health insurance company reviews a patient’s request for treatment. During the authorization request, your health insurance company will decide whether they are able to cover the requested treatment. A utilization review, typically completed by your treatment facility and/or provider, is a request for continued stay and additional days in treatment. During the utilization review, your insurance company will request information to meet medical necessity criteria according to The Milliman Care Guidelines ("MCG"), a set of health industry best practices, guidelines and diagnostic criteria published by MCG Health for providers and health plans.

Q: What are my options if my health insurance denied pre-authorization for my treatment or covering treatment services already rendered?

A: If your insurance company denies coverage for treatment services, you can submit an appeal for your health insurance to review their decision. The appeal process differs by health insurance company; you can find more information on your health insurance’s appeal process on their website or by calling Member Services. You can find more information about health insurance appeals here and here. If your appeal is denied, you may want to resubmit. If you believe the denial was unfair to the point of being illegal, you should consult an attorney (see list of legal practices that might be able to help LINK).

Q: How do I submit a Single Case Agreement (SCA)?

A: The process of coordinating a SCA varies by insurance provider. However, since SCAs involve both your insurance and your treatment provider, it is recommended to be in touch with both parties throughout the process so that everyone is on the same page.
Q: Will my health insurance cover treatment expenses from a facility located in a state different from where I live?

A: It depends on your insurance provider. Most insurance providers’ websites have a list of all of their in-network treatment providers, so it’s important to check there before your first treatment appointment.

Q: What is the Mental Health Parity and Addiction Equity Act (MHPAEA)?

A: The MHPAEA is a federal law that was signed in 2008. This law requires that insurance companies provide equivalent coverage for mental health and substance use services that they would for other health services. This law paved the way for in-network mental health coverage. However, it is underenforced. It is also proving insufficient for eating disorder treatment because medical care only includes hospital visits or office visits, while eating disorder treatment also includes residential, PHP, and IOP, which are not included under parity.

Health Plans that **MUST** follow parity:
- Group health plans for employers with 51+ employees
- Most group health plans for employers with 50 or fewer employees unless they have been “grandfathered,” which means it was created before the federal parity laws went into effect
- The Federal Employees Health Benefits Program
- Medicaid Managed Care Plans (MCOs)
- State Children’s Health Insurance Programs (S-CHIP)
- Some state and local government health plans
- Any health plans purchased through the Health Insurance Marketplaces
- Most individual and group health plans purchased outside the Health Insurance Marketplaces unless “grandfathered”

Health plans that **do NOT** have to follow parity:
- Medicare (except for Medicare’s cost-sharing for outpatient mental health services do comply with parity)
- Medicaid fee-for-service plans
- “Grandfathered” individual and group health plans that were created and purchased before March 23, 2010.
- Plans who received an exemption based on increase of costs related to parity

**Read more on the MHPAEA here**
**Q: Who can I talk to when I have questions about billing, coverage, etc.?**

**A:** When having questions related to billing or coverage of your insurance plan, it is best to call the Member Services number on the back of your insurance card. Depending on your plan, there may be different Member Services numbers to call, a separate one for medical and one for behavioral health. If you need to reach a separate department, a customer service representative will transfer you to the appropriate department.

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**Q: How to obtain a copy of my insurance benefits?**

**A:** A copy of your insurance benefits with the plan you have chosen should often be provided to you when you first enroll in your plan. This will often be in the form of a PDF, outlining the covered services, costs, premium, etc. If you do not have a copy of this, try looking on your insurance website, or speaking to your employer’s HR department (if insurance is through work), to obtain a copy. You may also call Member Services to request this document be emailed to you.

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**Q: My insurance does not cover pre-existing conditions and considers my eating disorder a pre-existing condition. How do I get treatment covered?**

**A:** As of 2014, Obamacare will prohibit insurance companies from excluding anyone with a pre-existing medical condition from coverage. If your insurance companies still reports they will not cover a pre-existing condition, you can seek help from a legal aide or other treatment advocate to assist in fighting for your eating disorder treatment to be covered.

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What is the Insurance Marketplace?

First – What is the Affordable Care Act (ACA)?

The Affordable Care Act, also known as “Obamacare,” was developed to help individuals access affordable health insurance through a health insurance Marketplace. The Affordable Care Act helps create a competitive private health insurance market, designed to put people in charge of their health coverage and care. These State-based, competitive marketplaces provide millions of Americans and small businesses with "one-stop shopping" for affordable coverage.

To purchase a plan through the insurance marketplace, sign up must be during open enrollment (a period each year when you can sign up for health insurance or change your plan). You may still be eligible to sign up for a plan outside of open enrollment if you had a qualifying life event (changing jobs, losing a job, getting married/divorced, moving, having a baby, etc).

The marketplace has several health insurance companies with many pros and cons varying in provider networks, deductibles, and other costs. The marketplace is set up to compare each plan and the pros and cons easily on the site.
Source: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces

So, what is the Marketplace?

The health insurance Marketplace are organizations, varying in plans by state, through which people can purchase health insurance. You can view and compare insurance for coverage and affordability, due to the ACA.
Common questions answered by the Marketplace on healthcare.gov:

Q: Can I apply for insurance through the Marketplace any time?

A: Marketplace plans can be purchased during:

1. Open Enrollment
2. Special Enrollment Period
3. Eligible for Medicaid or CHIP
4. Applied for Medicaid or CHIP during open enrollment and find out ineligible after open enrollment ends

The Open Enrollment Period typically occurs at the end of the year November 1 through January 15. Coverage will begin the first day of the month after you sign up.

With a Special Enrollment Period. If you lose job-based coverage, have a baby, get married, move, or have certain other life changes, you can enroll. If eligible, you may qualify for help paying for coverage, even if you weren’t eligible in the past. Learn more about lower costs.

Through Medicaid or the Children's Health Insurance Program (CHIP). You can apply any time and can enroll immediately if you're eligible. If you are denied coverage and deemed ineligible for Medicaid or CHIP after open enrollment ends, you will be able to apply for a new insurance plan through the Marketplace.

Q: How do I report changes to my income, family, or address?

A: You can report changes to the Marketplace 3 ways: online, by phone, or in person — not by mail.

It's important to report any changes as soon as possible. These changes may affect your coverage and savings.

Q: How do I submit documents?

A: You can upload the documents online, which is the fastest and easiest way to get them processed. Or you can mail copies instead.
Q: How do I pay my monthly premium to complete my enrollment?

A: When you have Marketplace insurance, you'll pay your premiums directly to the insurance company — not to the Health Insurance Marketplace®. Your coverage won’t start until you pay your first premium.

Get more information on completing your enrollment.

Q: How do I choose an insurance plan on the Marketplace?

A: If you are qualified for a health plan through the Affordable Care Act (through open enrollment or a qualifying life event), you can start by going to, you can apply for health coverage in several ways:

- Online at healthcare.gov
- By phone
- With the help of someone in your community
- Through an agent/broker
- Through certified enrollment partner websites
- With a paper application
- The most common, and easiest, way to review and choose a health plan is to go to healthcare.gov. This will allow you to visually view health plans side-by-side to compare coverage.

Health Plan Categories:

**Bronze Plan** – Estimated to cover 60% of medical bills, leaving the insured member to pay the remaining 40% up to established out-of-pocket maximum.

**Silver Plan** – Estimated to cover 70% of medical bills up to established out-of-pocket maximum.

**Gold Plan** – Covers 80% of medical bills up to established out-of-pocket maximum.

**Platinum Plan** – Estimated to cover 90% of medical bills up to established out-of-pocket maximum.

Plans will be available and vary by income.
Step-by-Step Guide to apply for insurance on the Marketplace:

- Apply online by going to [healthcare.gov](http://healthcare.gov)
- Click on “See If I can Enroll”
- If you are not sure if you qualify, you can type in your zip code to see if you qualify to change or add new health coverage in a special Open Enrollment Period. If it is an Open Enrollment Period (these dates will be available on the website), you should be able to qualify for new coverage.
- Once entering your zip code, you will be routed to the appropriate page for your state.
- The shop and compare tool will allow you to search for different monthly premiums, preferred providers, and eligibility for financial help towards your health insurance.
- You then will be prompted to create an account, if you do not already have one, and complete an application for eligibility, being Open Enrollment or a qualifying life event—the site will show eligible life events to choose form.
- Once completing your application and confirming your eligibility, you will click on “Shop for Plans.”
- All plans within your eligibility will appear on the site. You have the option to enter in your providers, to see if they accept the available health policies, and to filter preferences to narrow down the plans.
- Once choosing one that works best for you, you will select the plan, pay your first month’s premium, and set up a way to continue paying monthly.
- This can be a difficult and overwhelming decision. If you feel you need additional guidance before selecting your plan and would like to ask some questions, you may call 1-800-318-2596 or (TTY 1-855-889-4325) – available 24/7, other than on holidays.

*Last updated April 2022*
Consolidated Omnibus Budget Reconciliation Act (COBRA), 1985
COBRA gives workers and their families who lose their health benefits when leaving employment the right to choose to continue group health benefits through their employer. COBRA can be used for limited periods of time during voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other qualifying life events.

COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to provide notice.

The Emergency Medical Treatment and Labor Act (EMTALA), 1986
The EMTALA requires hospitals with dedicated emergency departments to provide medical care to anyone who asks for it, regardless of their ability to pay or health insurance status.

Health Insurance Portability and Accountability Act (HIPAA), 1996
HIPAA was passed in 1996 so that individuals could get copies of their medical records and other health information.

Pre-existing conditions under the Affordable Care Act (ACA), 2010
This law under the ACA protects you from being denied health insurance or charged more if you have a pre-existing condition — a health problem you had before the start date of your health plan.

Consolidated Appropriations Act, (CAA), 2021
The Consolidated Appropriations Act, 2021 (CAA) establishes protections for consumers related to surprise billing and transparency in health care.

Source:
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections

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# Eating Disorder Treatment

## Levels of Care

<table>
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<tr>
<th>Level of Care</th>
<th>How Does the Patient Qualify</th>
<th>What the Patient Can Expect</th>
<th>Does Insurance Provide Coverage</th>
</tr>
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<tbody>
<tr>
<td>Inpatient (IP)</td>
<td>• Patient is medically unstable&lt;br&gt;• Patient needs 24/7 supervision to stay safe</td>
<td>• Average stay stay ranges from 7 days – 1 month&lt;br&gt;• All meals and snacks are supervised&lt;br&gt;• Locked bathrooms&lt;br&gt;• Most therapy and nutrition sessions are group-based&lt;br&gt;• Patient lives on-site</td>
<td>• Yes, but prior authorization is needed</td>
</tr>
<tr>
<td>Residential (RES or RTC)</td>
<td>• Patient is medically and/or psychologically stable, but they need a structured environment away from home in order to recover</td>
<td>• Average length of stay ranges from a few weeks to one year&lt;br&gt;• All meals and snacks are supervised&lt;br&gt;• Program is a mix of group and individual therapy and nutrition sessions&lt;br&gt;• Patient lives on-site</td>
<td>• Often private insurance only, and prior authorization is needed&lt;br&gt;• SCA possible for private and public health plans, depending on plan and program</td>
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<tr>
<td>Partial Hospitalization Program (PHP or Day Treatment)</td>
<td>• Patient is physically and psychologically stable, but they need daily support to keep from declining</td>
<td>• Average length of stay is 4–8 weeks&lt;br&gt;• Program meets 5–7 days per week during the day&lt;br&gt;• At least two supervised meals per day&lt;br&gt;• Program is a mix of group and individual therapy and nutrition sessions&lt;br&gt;• Patient lives off-site</td>
<td>• Private insurance does&lt;br&gt;• Government funded typically when the program is hospital-based&lt;br&gt;• Prior authorization is often needed&lt;br&gt;• SCA possible for private &amp; public health plans</td>
</tr>
<tr>
<td>LEVEL OF CARE</td>
<td>HOW DOES THE PATIENT QUALIFY</td>
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<td>INTENSIVE OUTPATIENT (IOP)</td>
<td>• Patient no longer needs daily support, but they still need a structured environment for recovery</td>
<td>• Average length of stay is 6-12 weeks&lt;br&gt;• Program meets 3 days per week for 3 hours at a time&lt;br&gt;• One supervised meal per session&lt;br&gt;• Therapy and nutrition sessions may be individual and/or group-based&lt;br&gt;• Patient lives off-site</td>
<td>• Yes – often private insurance only, and prior authorization might be needed&lt;br&gt;• SCA possible for private and public health plans</td>
</tr>
<tr>
<td>OUTPATIENT (OP)</td>
<td>• Patient needs support to recover, but can function in their day-to-day life with low risk</td>
<td>• Treatment is ongoing, from a few months to a few years&lt;br&gt;• Treatment includes:&lt;br&gt;  o Individual therapy&lt;br&gt;  o Group therapy&lt;br&gt;  o Nutrition/dietitian therapy&lt;br&gt;  o Psychiatry appointments&lt;br&gt;  o Medical appointments</td>
<td>• Yes, but it is usually limited to in-network providers and there is rarely a mechanism to search for eating disorder specialists</td>
</tr>
<tr>
<td>INTENSIVE FAMILY TREATMENT (IFT)</td>
<td>• Patient is 24 or younger and lives with family of origin</td>
<td>• Entire family is included in treatment&lt;br&gt;• One-week intensive</td>
<td>• Rarely</td>
</tr>
<tr>
<td>FAMILY-BASED THERAPY (FBT)</td>
<td>• Patient is an adolescent or an adult who lives with family</td>
<td>• Treatment is therapist-led&lt;br&gt;• Focused on empowering parents to feed their child&lt;br&gt;• Typically runs for 20 sessions</td>
<td>• Rarely</td>
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**Source:** nationaleatingdisorders.org
SINGLE CASE AGREEMENTS (SCAs)

What is a SCA?

A Single Case Agreement (SCA) is a one-time contract between an insurance company and an out-of-network provider so the patient can see that provider using their in-network benefits. It is essentially an exception to the network so that the patient will only have to pay their routine in-network co-pays for sessions after meeting their in-network deductible (if any). The fee per session that will be paid by the insurance company is negotiated by the insurance company and the provider as part of the SCA.

SCAs can be justified when:

- The outpatient provider/treatment program has a clinical specialty, which is not available among any in-network provider
- The in-network provider does not treat people of your age, gender, or religious preference
- The geographical location of the patient does not have any in-network providers
- A patient who has recently changed their insurance plan or is stepping down to a different level of care at the same facility (continuity of care)
- All in-network providers are full and have no availability
- There is proof that the available in-network providers are inappropriate or would cause harm (e.g. the patient is transgender and they need a provider with expertise in transgender expertise)
- If a plan does have out-of-network benefits, the deductible, out-of-pocket max, and/or co-pay may be too costly financially
- SCAs can be obtained and are often needed Medicaid plans, when there are often no in-network options and no out-of-network benefits are available. This is especially common in Medicaid plans when residential level-of-care is being requested
- SCAs are possible for some Medicare plans, but it may be more difficult to obtain a SCA with Medicare than private plans or Medicaid plans - the best first step to request a SCA for Medicaid and Medicare is to request a behavioral health case manager (or Medicaid/Medicare may refer to case manager as case coordinators)

How do I set up a SCA?

SCAs are typically negotiated directly between your healthcare provider and your insurance company. When you first reach out to your healthcare provider for treatment, you can ask them whether they would be willing to negotiate a SCA with your insurance company. Be prepared to provide details about your medical history and whether you have received eating disorder treatment in the past. The stronger your case is that your chosen provider is the best care for you, the more likely your insurance company will agree to a SCA.
How long does a SCA last?

SCAs typically last for the length of your treatment. However, if you complete treatment with your provider and decide to resume treatment at a later date, you would need to negotiate a new SCA with your insurance company.

Steps to set up and advocate for a SCA:

- Start by contacting member services at your insurance company (behavioral/mental health number will often be on the back of your insurance card) to request a list of in-network (INN) providers/treatment facilities that specialize in eating disorders.

- If there are no INN providers available, ask if you have out-of-network benefits. Many insurance plans do not have out-of-network benefits. In this case, ask who you can speak to to determine if a single case agreement is possible. Inform them you have “exhausted all resources” and “there are no known residential eating disorder facilities INN” with your plan that meets _________ needs.

- When speaking with your insurance company, ask to be assigned a behavioral health case manager, if you do not already have one. This is a free enrollment, and your case manager will be your advocate from inside the insurance company, helping connect you to INN resources. Your case manager will be your point of contact at the insurance company. Tell the representative on the call this is urgent and contingent on you finding immediate treatment - this will hopefully lead to them getting back to you sooner rather than later. If you haven’t heard back in 1-2 weeks, do not be afraid to call back and be a squeaky wheel!

- If you do not have INN providers that meet your needs, research and call eating disorder treatment admissions to ask if they will work with your insurance by requesting a SCA. This will often vary by plan, and certain facilities will not work with Medicaid. Start will in-state or closer-by facilities, if possible - these are sometimes more likely to be approved for a SCA.

- Once you find a treatment center willing to work with your insurance, they will guide you through next steps in the process to be assessed and request the SCA.

- If you have outpatient providers (therapist/dietician/psychiatrist/PCP), it may be helpful to have them communicate with the treatment center to provide more rationale for your recommendation to a higher level of care and the need for a SCA. This may be helpful in gathering more information for insurance to meet “medical necessity criteria” for a SCA.

Last updated April 2022
If your health insurance denies coverage for your treatment, you can submit an appeal. There are two types of insurance appeals:

- **Internal appeal**: your insurance company does a “full and fair review” of its decision to deny coverage for treatment. You can learn more about internal appeals here.

- **External review**: an independent third party determines whether your insurance company should have denied coverage for treatment. You can learn more about external reviews here.

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**Appeal Letter Template 1** (source: University of Rochester Medical Center)

Dear [Appeals Analyst]:

I am writing, on behalf of [name of Plan member if other than yourself], to appeal the [name of Health Plan] decision to deny [name of service, procedure, or treatment sought] for [name of Plan member if other than yourself].

It is our understanding that [name of Health Plan] is denying coverage on the basis that “[cite Health Plan’s language in the denial letter].” [Attach denial letter.] We believe that [name of service, procedure, or treatment sought] is medically necessary to treat [name of Plan member if other than yourself]’s medical condition and that [name of service, procedure, or treatment sought] is a covered plan benefit.

[Name of Health Plan] covers medically necessary services that are not expressly excluded, which are described in the Evidence of Coverage and which are authorized by the member’s PCP and in some cases approved by an Authorized Reviewer. [Attach relevant section from Evidence ofCoverage.]

The entire treatment team has recommended that [name of service, procedure, or treatment sought] is medically necessary. [Attach supporting medical letter.]

Contrary to your letter, [name of service, procedure, or treatment sought] is a covered service. [Name of service, procedure, or treatment sought] is stated as a covered benefit in your HMO Member Handbook, is implicitly covered in the Evidence of Coverage, and is not expressly excluded as a covered service in the Evidence of Coverage. [Quote from Member Handbook and Evidence of Coverage to establish that the service, procedure, or treatment is a covered benefit and not expressly excluded.] [Cite your state’s mandated benefit laws requiring that the health plan provide this coverage.]
[Describe member's health condition, and why the service, procedure, or treatment would benefit the member and the consequences if the patient does not receive this treatment.]

[If the treatment is out-of-network, establish that there are no comparable services offered within the network.]

[Finally, if you feel they won’t cover the service because of the precedent, ask them to consider covering it as an extra-contractual benefit, and to pay for the service, procedure, or treatment out of the Health Plan’s catastrophic payment pool.]

[If the member requires immediate treatment for the condition, request an expedited hearing – request that they respond within 72 hours of mailing of the letter. Note that ACA now requires a 72-hour expedited internal review for urgent care. This time frame is required for plan years or policy years beginning on July 1, 2012.]

[Attach a letter from your treating physician describing the person’s condition.]

Thank you for your immediate attention to this matter.

Sincerely,

[Your name]

cc: [Possible people to whom you should consider sending copies of your letter including Health Plan Medical Director; Medical Group; Medical Director; Your primary care or treating physician; Your state representative if you expect more denials]
**APPEALING INSURANCE DENIALS**

**Appeal Letter Template 2** (source: Journal of Psychiatric Practice: Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients)

By Joseph Feldman, MBA Mark DeBofsky, JD Eric M. Plakun, MD Cheryl Potts, MBA

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**TEMPLATE FOR A MEDICAL NECESSITY LETTER**

*Date:
To Whom It May Concern:*

This letter describes my clinical assessment and the medically necessary treatment for my patient [patient]. I have been treating [patient] since approximately [date].

[**Provider credentials and practice**]— include a brief summary of your training, medical or other professional school, residency, fellowship and internship training, hospital affiliations, years in practice, peer-reviewed publications in the area in question, relevant specialties relevant to the specific patient, and any other description of your qualifications that inform your professional judgment. The information included here will establish your qualifications to make the clinical determination to be described below.

[**Substantiated clinical assessment**]— include a brief summary of your diagnosis/assessment, focusing on the particulars relevant to the medically necessary treatment that you have determined is appropriate including:

- Related observations that informed your determination of the treatment plan.

- Peer-reviewed standards and medical treatment guidelines that informed your judgment. (Guidelines may include LOCUS,8 CALOCUS,8 ASAM,9 DSM–5,13 Psychiatry Online guidelines,10 AACAP primary case guidelines,11 Nice (UK) guidelines,12 and institutional guidelines.) To the extent that this particular patient’s needs vary from or are atypical vis-à-vis standards and guidelines, it would be helpful to include relevant commentary.

- Considerations related to standards of care and other references based on the Wit v United Behavioral Health lawsuit (see Appendix B “Suggested Text for Potential Inclusion in a Medical Necessity Letter”). (It is neither necessary nor appropriate (a) to speculate on the probability of success with any particular course of treatment, (b) to explore any “what ifs” regarding the potential evolution of the treatment, or (c) to assess whether or not the insurance policy will cover the treatment. Your current assessment is sufficient.)
[Course of treatment]— description of the course of treatment that you have determined to be medically necessary, including:

- **Summary rationale for your medical decision-making.**

- When possible, link your recommendation for medically necessary treatment to a professional society multidimensional assessment instrument, such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) or the Child and Adolescent Level of Care Utilization System (CALOCUS) developed by the American Association of Community Psychiatrists or the American Society of Addiction Medicine (ASAM) criteria. Also include reference to the relevant elements of effective treatment from the Wit lawsuit (specific suggestions are provided in Appendix B to this article).

- Be sure to use the words “determined to be medically necessary”; leave no doubt that “medically necessary” is the standard for your treatment decision.

- Identify (a) specific harms that could occur, (b) avoidable risks that could be mitigated, and/or (c) clinical gains that could be lost absent your planned course of treatment.

- This letter is neither a recommendation for approval nor the persuasive presentation of evidence for evaluation by others. Rather, it introduces you and your expertise, summarizes your relationship with and assessment of the patient, and your (by now, obviously qualified) determination.

Sincerely,

[Signature]

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Last updated April 2022
LEGAL SUPPORT

Legal Practices that Work on Eating Disorder Litigation

- Berger & Green (PA)
- Disability Insurance Law Group (FL)
- Kantor & Kantor, LLP (CA, OR, and WA)
  - Q & A with Lisa Kantor: How to Get Coverage for the Treatment of My Eating Disorder
- Law Offices of Scott Glovsky (CA)

Legal Practices that Deal with Health Insurance and Parity Violations

- The Kennedy Forum
- Crowell & Moring LLP (Kathy Hirata Chin in particular) (NY)
- DeBofsky Sherman Casciari Reynolds P.C. (IL)
- Dickinson Wright LLP (AZ, CA, FL, KY, MI, OH, NV, TN, TX, and Washington DC)
- Epstein Becker & Green (CA, CT, FL, IL, MD, MI, NJ, NY, TN, TX, and Washington DC)
- Hall Render Killian Heath & Lyman (AK, CO, IN, MD, MI, NC, TX, WA, WI, and Washington DC)
- Napoli Shkolnik PLLC (Matthew Lavin in particular) (Washington DC)
- Psych Appeal (CA)
- Zuckerman Spaeder (FL, MD, NY, and Washington, DC)
<table>
<thead>
<tr>
<th>Treatment Facility</th>
<th>Location</th>
<th>Level of Care</th>
<th>Who can be treated</th>
<th>Medicare/Medicaid/Other</th>
<th>Contact</th>
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<tbody>
<tr>
<td>Rosewood Centers for Eating Disorders</td>
<td>Wickenburg, AZ</td>
<td>IP (NG tubes), RTC, PHP, IOP</td>
<td>Adults, all genders</td>
<td>AZ Medicaid, NM Medicaid, SCA with Medicaid in surrounding states</td>
<td>928.223.6084</td>
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<tr>
<td>[A Monte Nido Affiliate]</td>
<td></td>
<td>Co-occurring addiction with detox</td>
<td></td>
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<td></td>
<td></td>
<td>*Diabulimia</td>
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<td>Beowers Eating Disorder Center</td>
<td>Rosemead, CA</td>
<td>IP, RTC, PHP, IOP, virtual OP</td>
<td>Adults, all genders</td>
<td>MediCare, MediCal, Tricare West/East</td>
<td>844.573.2766</td>
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<tr>
<td>Amrita Eating Disorder Treatment Center</td>
<td>San Rafael, CA</td>
<td>IOP</td>
<td>Adults, adolescents, all ages</td>
<td>MediCal</td>
<td>415.570.2270</td>
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<tr>
<td>Alta Bates Summit Eating Disorders Program</td>
<td>Berkeley, CA</td>
<td>IP, PHP, IOP</td>
<td>Adults, adolescents, all genders</td>
<td>MediCal, Medicare</td>
<td>510.204.4405</td>
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<td>Center for Discovery</td>
<td>CA- several locations</td>
<td>RTC, PHP, IOP</td>
<td>Adults, adolescents, all genders</td>
<td>MediCal - SCA needed with county</td>
<td>844.521.1337</td>
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<tr>
<td>UCSF Eating Disorders Program - The University of CA</td>
<td>San Francisco, CA</td>
<td>IP, Intensive Family Treatment for adolescents</td>
<td>Adults up to age 25, adolescents, children, all genders</td>
<td>MediCal, Medicare</td>
<td>415.514.1074</td>
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<td>Sharp Mesa Vista Hospital</td>
<td>San Diego, CA</td>
<td>IP, PHP, IOP</td>
<td>Adults, all genders</td>
<td>MediCare, Molina, Medicare, Tricare, Tricare for Life, Champus/Tricare</td>
<td>858.836.8434</td>
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<tr>
<td>Eating Disorders Program at Torrance Memorial Hospital</td>
<td>Torrance, CA</td>
<td>IP Acute stabilization- will be covered under medical benefits instead of behavioral due to being acute care facility</td>
<td>Adults &amp; adolescents ages 13-26, all genders</td>
<td>Medicare, Secure Horizons Medicare, Central Health Plan Medicare, SCAN Health Plan Medicare, Care 1st (Medicare HMO only), Medi-Cal (not a participating provider for Medi-Cal HMO, Tricare for Life, Champus/Tricare</td>
<td>310.325.4353</td>
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<td>EDCare</td>
<td>Denver, CO</td>
<td>PHP, IOP</td>
<td>Adults, all genders</td>
<td>CO Medicaid: CO Access, Rocky Mountain Health Plains, Tricare</td>
<td>720.686.3064</td>
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<td>La Luna Center</td>
<td>Boulder, CO</td>
<td>PHP, IOP</td>
<td>Adults ages 58+, all genders</td>
<td>Health First CO Medicaid: CCHA, RMHP, CO Access; HealthPartners of MN &amp; WL Rocky Mountain Health Plans</td>
<td>720.470.0010</td>
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<td>Fort Collins, CO</td>
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<td>Colorado Therapy &amp; Assessment Center</td>
<td>Denver, CO</td>
<td>OP: individual, group, &amp; family therapy</td>
<td>All ages and genders</td>
<td>Medicare, ALL CO Medicaid; Beacon Medicaid, Denver Health Medicaid, Rocky Mountain Health Plans Medicaid, CO Access Medicaid, CCHA CO Community Health Alliance</td>
<td>720.515.4244</td>
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<tr>
<td>State</td>
<td>Facility Name</td>
<td>Location</td>
<td>Services Provided</td>
<td>Admitted Ages</td>
<td>Gender Identification</td>
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<td>Connecticut</td>
<td>Walden Eating Disorder Center</td>
<td>Guilford, CT</td>
<td>IP, RTC, PHP, IOP</td>
<td>Adults, adolescents, children, all genders</td>
<td>Medicare IP only, Husky Health CT Medicaid (Husky covers PHP/IOP; SCA for RTC not possible)</td>
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<td>Florida</td>
<td>Rogers Behavioral Health</td>
<td>Tampa, FL</td>
<td>PHP, IOP</td>
<td>Adults, adolescents, children, all genders</td>
<td>Medicare</td>
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<td>Canopy Cove Eating Disorder Treatment Center</td>
<td>Tallahassee, FL</td>
<td>RTC</td>
<td>Adults, adolescents, female-identifying</td>
<td>Ambetter GA &amp; FL, Ambetter SCA with other states, FL, Medicaid, SCA for out-of-state Medicaid</td>
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<td>ViaMar Health</td>
<td>West Palm Beach, FL</td>
<td>RTC, PHP, IOP</td>
<td>Adults, adolescents ages 12-17, all genders</td>
<td>FL, Blue Medicaid, KT &amp; CO Medicaid, Ambetter SCA, Tricare</td>
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<td>Georgia</td>
<td>Manna Treatment</td>
<td>Duluth, GA</td>
<td>PHP, IOP Medication management</td>
<td>Adults, adolescents, all genders</td>
<td>Peach State Health Plan, Amerigroup, Medicaid, Medicare</td>
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<td>Veritas Collaborative</td>
<td>Dunwoody, GA</td>
<td>IP (NG tubes), RTC, PHP, IOP</td>
<td>Adults, adolescents, children, all genders</td>
<td>GA Medicaid, Amerigroup GA Medicaid, SCA with surrounding state Medicaid</td>
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<td>Hawaii</td>
<td>'Ai Pono Eating Disorder Program</td>
<td>Wailuku, HI</td>
<td>RTC, IOP</td>
<td>RTC- Adults, adolescents ages 13+, female-identifying</td>
<td>Hawaii State Medicaid, Ohana Health Plan Medicaid, AlohaCare Medicaid, Tricare, VA</td>
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<td>Illinois</td>
<td>Alexian Brothers - AMITA Health</td>
<td>Hoffman Estates, IL</td>
<td>IP, PHP, IOP, OP</td>
<td>IP/PHP/IOP/OP- adults, all genders</td>
<td>Medicare Advantage Plans, II, Medicaid: Blue Cross Community, County Care, IlliniCare, Molera, Meridian, Dual Medicare/Medicaid Plans; Tricare, VA</td>
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<td>OSF Saint Francis - Behavioral &amp; Mental Health</td>
<td>Peoria, IL</td>
<td>PHP, IOP</td>
<td>Adults, adolescents, all genders</td>
<td>Medicare: Dual Medicaid/Medicare plans; IlliniCare, Aetna Better Health, Molina Healthcare, BC Community, Humana Gold Plus; Medicare Parts A&amp;B, Medicare Advantage Plans, Medicare Supplemental, Medicare Select Plans, USA Senior Care, (Medicare Select Plan), Wellcare, WellFirst, Aetna Medicare, Ameri-Plus; Medicaid: Aetna Better Health, IN Medicaid, Neridian, BCBS Community Health Plan, County Care, II, Medicaid, MI Medicaid, Molina, VA</td>
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<td>State</td>
<td>Facility Name</td>
<td>Location, State</td>
<td>Services</td>
<td>Population</td>
<td>Insurance Options</td>
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<td>Illinois</td>
<td>Linden Oaks Behavioral Health</td>
<td>Naperville, IL</td>
<td>RTC, PHP, IOP, OP</td>
<td>Adults, adolescents ages 13+, all genders</td>
<td>Medicare, Medicaid, Tricare</td>
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<td>University of Iowa Eating Disorder Program</td>
<td>Iowa City, IA</td>
<td>IP, PHP, OP</td>
<td>Adults, all genders</td>
<td>Medicare, Medicaid, Tricare</td>
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<td>Louisiana</td>
<td>River Oaks</td>
<td>New Orleans, LA</td>
<td>IP, PHP</td>
<td>Adults, all genders</td>
<td>Medicare, Medicaid: Healthy Blue Louisiana (no out-of-state Medicaid), Tricare</td>
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<td>Maine</td>
<td>The Eating Disorder Center at Crossroads Back Cove</td>
<td>Portland, ME</td>
<td>RTC, Dual drug &amp; alcohol</td>
<td>Female-identifying adults</td>
<td>MaineCare, Maine Community Health Options, Martin's Point Healthcare</td>
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<td>Maryland</td>
<td>Johns Hopkins Eating Disorders Program</td>
<td>Baltimore, MD</td>
<td>IP, PHP, OP</td>
<td>Adults, adolescents, all genders</td>
<td>MD Medicaid (no out-of-state), Maryland Medical Assistance (no out-of-state medical assistance), Priority Partners is the only Maryland Medicaid MCO; Medicare A&amp;B, limited Medicare Advantage Plans: Geisinger Gold Medicare Advantage, Kaiser Medicare Advantage HMO; Aetna Medicare HMO/PPO; Tricare</td>
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<td>The Center For Eating Disorders - Sheppard Pratt</td>
<td>Baltimore, MD</td>
<td>IP, PHP, IOP</td>
<td>Adults, adolescents, children ages 12+, all genders</td>
<td>MD Medicaid, Medicare</td>
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<td>Massachusetts</td>
<td>Klarmen Eating Disorders Center - McLean Hospital</td>
<td>Belmont, MA</td>
<td>RTC, PHP, Virtual OP</td>
<td>Female-identifying adults/adolescents, ages 16-26</td>
<td>Medicare Advantage, Tricare East/West for Life, MassHealth Medicaid, ConnectiCare, Tufts Health, BMC Healthnet, AllWays Health Partners, WV UniCare</td>
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<td>Walden Eating Disorder Center (A Monte Nido Affiliate)</td>
<td>Waltham, MA</td>
<td>IP, PHP, IOP</td>
<td>Adults, adolescents ages 11+, all genders</td>
<td>Medicare Part A, Well Sense Medicaid (adolescent IP only), Tufts Health Plan, CDPHP, Fallon Care, Commonwealth Care Alliance, MassHealth Medicaid, MBHP, Tricare North</td>
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<td>State</td>
<td>Name</td>
<td>City, State</td>
<td>Services</td>
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<td>Insurance</td>
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<td>Michigan</td>
<td>A Healing Place, LLC</td>
<td>Jackson, MI</td>
<td>OP ED Group Therapy, OP</td>
<td>Adults, adolescents, children, all genders</td>
<td>Medicare, Medicaid, Dual Medicare-Medicaid Plans, Tricare, VA, Ambetter, Health Alliance Plan</td>
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<td>The Michigan Medicine Comprehensive Eating Disorders Program</td>
<td>Ann Arbor, MI</td>
<td>IP, PHP IOP</td>
<td>Ages 8-22, all genders</td>
<td>Medicare, Medicaid</td>
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<td>The Eating Disorders Program at Forest View Hospital</td>
<td>Grand Rapids, MI</td>
<td>IP, PHP (Virtual available), Medication management</td>
<td>Adults, adolescents, children, all genders</td>
<td>Medicare, Medicaid</td>
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<td>Sanford Behavioral Health</td>
<td>Grand Rapids, MI</td>
<td>RTC, PHP, IOP, OP</td>
<td>RTC- female-identifying adults, ages 18+ PHP/IOP/OP- adults &amp; adolescents, all genders</td>
<td>Medicare, Medicaid</td>
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<td>Minnesota</td>
<td>Water’s Edge Counselling &amp; Healing Center</td>
<td>Burnsville, MN</td>
<td>PHP, IOP, OP, FBT</td>
<td>Adults, adolescents ages 12+, all genders</td>
<td>Behavioral Health Care Providers (BHP), Health Partners, Medical Assistance/MN Care, Medicare, UCare, Tricare, Champ VA</td>
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<td>Melrose Center</td>
<td>St. Louis Park, MN, St. Paul, MN, Maple Grove, MN, Burnsville, MN, Lake Elmo, MN</td>
<td>RTC, PHP, IOP, FBT, OP, Virtual support group Dual drug &amp; alcohol</td>
<td>Adults, adolescents ages 12+, all genders</td>
<td>HealthPartners, Medicaid, Medica, Medicare</td>
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<td>The Emily Program</td>
<td>Minneapolis, MN, Duluth, MN, St. Paul, MN, St. Louis Park, MN</td>
<td>RTC, PHP, IOP</td>
<td>Adults, adolescents, all genders</td>
<td>HealthPartners, Medical Assistance, MN Medicaid, South Country Health Alliance, Medica, Medicare</td>
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<td>Montana</td>
<td>Emily Wish, LLC</td>
<td>Great Falls, MT</td>
<td>IOP, OP, FBT</td>
<td>Adults, adolescents, children, all genders</td>
<td>MT Medicaid, Tricare, TriWest</td>
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<td>Nebraska</td>
<td>EDCare</td>
<td>Omaha, NE</td>
<td>IOP</td>
<td>Adults, all genders</td>
<td>NE Medicaid, Ambetter</td>
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<td>Omni Inventive Care Eating Disorder Clinic</td>
<td>Omaha, NE</td>
<td>PHP, IOP, OP</td>
<td>Adults, adolescents, all genders</td>
<td>NE &amp; IA Medicaid</td>
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<td>New Jersey</td>
<td>Princeton Center for Eating Disorders at Penn Medicine</td>
<td>Plainsboro, NJ</td>
<td>IP</td>
<td>Adults, adolescents, children 8+, all genders</td>
<td>Medicare, Tricare, Amerigroup Apple Health</td>
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<td>Program</td>
<td>Location</td>
<td>Services</td>
<td>Client Groups</td>
<td>Insurance Acceptance</td>
<td>Phone</td>
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<td>Eating Disorders Treatment Center, LLC</td>
<td>Albuquerque, NM</td>
<td>PHP, IOP, OP</td>
<td>Adults, adolescents, children, all genders</td>
<td>Tricare West, Molina, New Mexico Medicaid: BCBS, Western Sky, Presbyterian, True Health New Mexico</td>
<td>505.266.6121</td>
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<td>New Mexico Eating Disorders Treatment Center, LLC</td>
<td>White Plains, NY</td>
<td>IP, PHP, OP</td>
<td>Adults, adolescents ages 13+, all genders</td>
<td>Medicare, wide range of NY Medicaid</td>
<td>914.682.5475</td>
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<td>John T Mather Memorial Hospital</td>
<td>Port Jefferson, NY</td>
<td>PHP, IOP</td>
<td>Adults, adolescents, all genders</td>
<td>VA, Tricare, United HealthCare Community Plan, Medicare, Medicaid, WellCare Medicaid &amp; Medicare HMO, WellCare Child Health Plus, Fidelis, HealthFirst, HealthSmart, HealthCare Partners, MagnaCare</td>
<td>631.473.1320</td>
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<td>New York Presbyterian Center for Eating Disorders</td>
<td>Rochester, NY</td>
<td>PHP, IOP, OP</td>
<td>Adults, adolescents, children ages 12+, all genders</td>
<td>NY Medicaid Managed Care: CDPHP, Excellus, EmblemHealth, Fidelis Care, MVP Health Care, Molina Health of NY, UHC of NY, VNC Choice: NY Medicaid Advantage Plus</td>
<td>585.641.0281</td>
</tr>
<tr>
<td>The Healing Connection, Inc</td>
<td>Wilmington, NC</td>
<td>IOP (adults only), OP</td>
<td>Adults, adolescents, all genders</td>
<td>Medicare, Tricare</td>
<td>910.790.9300</td>
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<tr>
<td>NC Center for Excellence for Eating Disorders</td>
<td>Chapel Hill, NC</td>
<td>IP, OP</td>
<td>Adolescents/adults ages 13-25, all genders</td>
<td>Medicare, NC &amp; VA Medicaid</td>
<td>984.974.3834</td>
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<tr>
<td>Duke Center for Eating Disorders</td>
<td>Durham, NC</td>
<td>OP individual, family, group, and meal support</td>
<td>Adults, adolescents, children, all genders</td>
<td>Medicare MultiPlan, Tricare, Medicaid: NC, Optima Medicaid VA, Ambetter NC, All Savers</td>
<td>919.668.0398</td>
</tr>
<tr>
<td>TranscendED</td>
<td>Matthews, NC</td>
<td>PHP, IOP, OP</td>
<td>Adults, adolescents, children ages 11+, all genders</td>
<td>NC Medicaid: Cardinal Innovations</td>
<td>704.708.4605</td>
</tr>
<tr>
<td>UNC Center of Excellence for Eating Disorders, NC</td>
<td>Fletcher, NC, Breverd, NC</td>
<td>RTC, PHP, IOP</td>
<td>Adults, adolescents, all genders</td>
<td>Carolina Behavioral Health Alliance, South Carolina Healthy Connections Medicaid, Behavioral Health Services Medicaid</td>
<td>828.521.0919</td>
</tr>
<tr>
<td>Tapestry Adolescent Eating Disorder Program</td>
<td>Wilmington, NC</td>
<td>IOP (adults only), OP</td>
<td>Adults, adolescents, all genders</td>
<td>Medicare, Tricare</td>
<td>910.790.9300</td>
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<tr>
<td>Chrysalis Center For Counseling &amp; Eating Disorder Treatment</td>
<td>Wilmington, NC</td>
<td>IOP (adults only), OP</td>
<td>Adults, adolescents, all genders</td>
<td>Medicare, Tricare</td>
<td>910.790.9300</td>
</tr>
<tr>
<td>Veritas Collaborative</td>
<td>Charlotte, NC</td>
<td>IP (NG tubes), PHP, IOP</td>
<td>Adults, adolescents, children, all genders</td>
<td>TennCare Medicaid, SCA with surrounding state Medicaid</td>
<td>855.875.3812</td>
</tr>
<tr>
<td>State</td>
<td>Location</td>
<td>Specialties</td>
<td>Target Population</td>
<td>Insurance Accepted</td>
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</tr>
<tr>
<td>North Dakota</td>
<td>Sanford Eating Disorders Center, Fargo, ND</td>
<td>IP (NG tubes), PHP, OP Sanford Pediatric Feeding Disorders Program ages birth-12 (PHP, IOP), all genders</td>
<td>Adults &amp; adolescents, all genders</td>
<td>Medicaid, Medicare, HealthPartners, SCA with Medicaid in surrounding states</td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>Center for Behavioral Health at Cleveland Clinic, Cleveland, OH</td>
<td>IP</td>
<td>Adults, adolescents, all genders</td>
<td>Medicaid: Buckeye Community Health Plan, CareSource, Molina, Paramount Advantage, UHC Community Plan of OH, Medicare Advantage Plans, Medicare/Medicaid Dual Plans; Buckeye AllWell Dual Special Needs Plan (DSNP) – Does not include Buckeye AllWell Medicare HMO, Molina Healthcare MyCare, MyCare, CareSource DSNP, Buckeye MyCare, UHC Community Plan, MyCare Ohio</td>
<td></td>
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<tr>
<td></td>
<td>Lindner Center of HOPE, Mason, OH</td>
<td>IP, PHP, IOP</td>
<td>Adults &amp; adolescents, all genders</td>
<td>Ambetter, Medicare, AllWell Medicare, Valor Health Plan Medicare, UHC Dual Plans, OH Medicaid, MediBlue Plans</td>
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<tr>
<td></td>
<td>The Emily Program, Cleveland, OH, Columbus, OH</td>
<td>RTC, PHP, IOP</td>
<td>Adults, adolescents, all genders</td>
<td>Molina, Ohio Health/Optima Health, SummaCare, Medical Mutual of OH, Mutual Health Services</td>
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<tr>
<td>Oklahoma</td>
<td>Living Hope Eating Disorder Treatment Center, Norman, OK</td>
<td>RTC (ages 16+), PHP, IOP</td>
<td>Adults, adolescents ages 13+, all genders</td>
<td>Medicare, Care Credit accepted</td>
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<tr>
<td></td>
<td>The Laureate Eating Disorders Program - Laureate Psychiatric Facility &amp; Hospital, Tulsa, OK</td>
<td>IP psychiatric, acute care hospitalization, RTC, PHP</td>
<td>Adults, adolescents ages 11-17, all genders</td>
<td>Community Care, Preferred Community Choice, Medicare</td>
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<tr>
<td>Oregon</td>
<td>Kartini Clinic for Children &amp; Families, Portland, OR</td>
<td>IP, PHP, IOP, OP</td>
<td>Adolescents, children up to age 18, all genders</td>
<td>OR Health Plan &amp; Washington Apple Health Managed Care (Medicaid), Medicaid SCA</td>
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<td></td>
<td>Madrone Mental Health Services, Eugene, OR</td>
<td>Adult PHP, OP, Med Management</td>
<td>Adult, adolescent, children aged 6+, all genders</td>
<td>Medicaid, OR Health Plan</td>
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</table>

701.417.5399

216.636.5860

513.536.4673

888.364.3977

833.206.6921

918-491-3700

971.319.6800

541.668.8046
<table>
<thead>
<tr>
<th>Pennsylvania</th>
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<tbody>
<tr>
<td>The Renfrew Center</td>
<td>Spring Lane, PA</td>
<td>RTC (NG tubes)</td>
<td>Female-identifying, Adults, adolescents, ages 14+ *Diabulimia</td>
<td>Fidelis Health NY Medicaid</td>
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<tr>
<td>White Pine Center for Healing</td>
<td>Eerie, PA</td>
<td>IOP, OP</td>
<td>Adults, adolescents, children aged 6+, all genders</td>
<td>Medicaid</td>
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<tr>
<td>Penn State Eating Disorders Program</td>
<td>Hershey, PA</td>
<td>PHP, IOP, BED Clinic</td>
<td>Adults, adolescents, children ages 10+, all genders</td>
<td>Actina Better Health, AmeriHealth Caritas Medicaid MCO Plans, HealthPartners, CHIP plans, Medical Assistance of PA, Medicare, Medicare Advantage Plans, Tricare</td>
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<tr>
<td>Tennessee</td>
<td></td>
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<tr>
<td>Focus Treatment Centers</td>
<td>Chattanooga, TN</td>
<td>RTC, PHP, IOP</td>
<td>Adults 18+, all genders</td>
<td>BlueCare TN Medicaid</td>
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<td>Utah</td>
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<tr>
<td>Center For Change</td>
<td>Orem, UT Cottonwood Heights, UT</td>
<td>IP, RTC, PHP, IOP, OP Transitional Living Co–occurring drug &amp; alcohol</td>
<td>Adults, adolescents ages 13+, all genders</td>
<td>Medicaid, SelectHealth, Tricare, TriWest, Deseret Mutual (DMBA)</td>
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<tr>
<td>Virginia</td>
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<tr>
<td>Reflections Eating Disorder Treatment at Dominion Hospital</td>
<td>Falls Church, VA</td>
<td>IP, PHP</td>
<td>Adults, adolescents, all genders</td>
<td>Tricare Medicare Parts A&amp;B Medicaid; Amerigroup Apple Health, Anthem HealthKeepers Plus, VA Medicaid, FAMIS Plus</td>
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</table>
### Washington

<table>
<thead>
<tr>
<th>Clinic Name</th>
<th>Location</th>
<th>Services</th>
<th>Eligibility</th>
<th>Insurance</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Emily Program</td>
<td>Seattle, WA, Spokane, WA, Lacey, WA</td>
<td>RTC (ages 18+), PHP, IOP</td>
<td>Adults, adolescents, all genders</td>
<td>Amerigroup WA Medicaid, Optum Medicaid, Community Health Plan of WA, UHC Community Plan, Molina</td>
<td>888.364.5977</td>
</tr>
<tr>
<td>Eating Disorder Clinic at Seattle Children’s Hospital</td>
<td>Seattle, WA</td>
<td>IP</td>
<td>Children/adolescents ages 10-18, all genders; Ages 19-21 (1x consultation)</td>
<td>If your child is covered by Washington Apple Health, we accept all Medicaid Managed Care Organization plans (Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina and United Health Care Community Plan).</td>
<td>206.987.2028</td>
</tr>
<tr>
<td>Recovery and Wellness Center – of Eastern WA Treatment Programs for Eating Disorders, Anxiety, &amp; Depression</td>
<td>Richland, WA</td>
<td>PHP, IOP</td>
<td>Adults, adolescents ages 13+, all genders</td>
<td>Some forms Medicaid through SCA – Molina, Coordinated Care, Community Health Plan of WA (more likely if adolescent, possibly adults for Coordinated Care and Community Health Plan of WA).</td>
<td>509.619.0519</td>
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</tbody>
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### Wisconsin

<table>
<thead>
<tr>
<th>Clinic Name</th>
<th>Location</th>
<th>Services</th>
<th>Eligibility</th>
<th>Insurance</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rogers Behavioral Health</td>
<td>Oconomowoc, WI</td>
<td>IP, RTC</td>
<td>Adults, adolescents 12-17 y/o</td>
<td>Medicare IP only, Medicaid: WI &amp; MN</td>
<td>800.767.4411</td>
</tr>
<tr>
<td>Evolve Healing</td>
<td>DePere, WI, Oshkosh, WI, Stevens Point, WI</td>
<td>RTC, PHP, IOP, OP Transitional Housing</td>
<td>Adults, adolescents, children ages 12+, all genders</td>
<td>HealthPartners of MN and WI, Medicaid, Molina, Medicare, Tricare/Humana, Tricare East, VA, Medica</td>
<td>920.364.9078</td>
</tr>
</tbody>
</table>