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 of Coverage.]*

*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]
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

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]

Please click below to view more sample appeal letters:

Sample Letters To Use With Insurance

Submitting Appeals To Insurance For OSFED Treatment Denial

Last updated July 2022
APPEALS PROCESS

1. Peer to Peer
   A Peer to Peer is a phone conversation between your treatment provider (typically a psychiatrist or licensed therapist) and a doctor (MD) at the insurance company. This occurs when a request for services is being considered for denial by insurance.

2. Internal Appeal
   If the MD denies services in the peer to peer, an internal appeal may be requested to assess whether or not the correct determination was made when the services were denied. This may involve another conversation between your treatment team and MD, or a review of medical records, or both. Typically, this will be requested as an "expedited appeal" and will take place within 48-72 hours.

3. Level 2 Internal Appeal
   If the MD denies services in the peer to peer, an internal appeal may be requested to assess whether or not the correct determination was made when the services were denied. This may involve another conversation between your treatment team and MD, or a review of medical records, or both. Typically, this will be requested as an "expedited appeal" and will take place within 48-72 hours.

4. External Appeal
   If the MD denies services in the peer to peer, an internal appeal may be requested to assess whether or not the correct determination was made when the services were denied. This may involve another conversation between your treatment team and MD, or a review of medical records, or both. Typically, this will be requested as an "expedited appeal" and will take place within 48-72 hours.

*This appeal process varies by policy and does not apply to Medicaid, Medicare, or Tricare policies.

Click Here to learn more about the Medicare appeals process
Click Here to learn more about the Tricare appeals process