

In This Guide

How to appeal an insurance claim or treatment denial



Step 1:

Determine what type of insurance you have.

Before seeking to enforce your rights, you must know your rights. If you have a health care coverage agreement from a third party then the odds are you receive that coverage from a health insurance company, a managed health care plan provider, a self-insured association, or the government. The most straightforward way to determine what type of policy or plan you entered into is to check your enrollment form. An enrollment form is a document that one signs to give notice of their desire to participate in the benefits of a plan.

Step 2:

Understand your coverage.

Most plans have a Certificate of Benefits (also known as an Evidence of Coverage) that specifically describes the health care benefits covered by your health plan, or something similar. Check your documents or call your health plan and ask them where you can find a list of your benefits. Some States, like California, have laws like the Patient Protection and Affordable Care Act (commonly referred to as “Obamacare”), that defined minimum benefits. Obamacare under California law requires coverage to include “essential health benefits” that include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Step 3:

Benefits you may be entitled to not explicit in your policy.

Health insurance companies and managed health plan providers will often deny coverage for such benefits and merely hope that the subscriber or insured is too ignorant to know their rights. This most commonly happens when a consumer seeks mental health treatment coverage. Certain autism treatments are also generally not explicit in an insurance policy, but may be required treatments under the law (as they are in California). These are trickier to determine and you should check with a lawyer or a large advocacy group in your State that fights for the treatment or services you’re seeking.

Step 4:

Gather all information and documents about your claim or treatment denial.

Document all communications that you have or have had with the insurance company or health plan manager. This means collect copies of all letters that the insurance company or health plan manager sent to you and all letters that you sent to the insurance company or health plan manager. If you had any phone conversations with the insurance company or health plan manager then be sure to keep a log of the time and date of the conversation, the name, title, and/or employee identification number of the person with whom you talked, and a description of everything that was said during the conversation. It is also necessary for you to collect as much medical evidence concerning your need for the treatment at issue as possible. This means gather copies of your medical records and all referrals from health care professionals. It is important that you learn the complete basis for the denial and have the insurance company or health plan manager commit to their position and reasoning in writing.

Step 5:

Internal appeals process.

Insurance companies and managed health care providers have internal appeal processes that are required by law. We recommend highly that before you begin to learn about the appeal process of your specific insurance or managed health plan company that you contact a lawyer who is knowledgeable and has experience with health care coverage issues.

A lawyer can advise you as to how to best structure your appeal so that you get the results that you deserve. Each insurance company and health plan manager has a different internal appeal procedure. You need to determine their appeals process and if you choose to appeal, as opposed to hire a lawyer, you need to follow their appeals process.

If you write an appeal letter then the things that are important to include are your name, contact information such as your address and phone number, and information about your policy including the policy number, the group number, and the claim number. You should also include as much written evidence as you have such as doctors letters and medical records but always keep a copy of anything that you send. It is important to keep in mind that many companies have time limits for their internal appeal process. When you receive a denial of your coverage claim, you should immediately look into the time requirements for the internal appeal process so that you can determine by when you will have to file an appeal, should you choose to do so. If you miss these deadlines than you can lose your opportunity to have the denial appealed at all.

Step 6:

External appeals process.

It is possible that after the internal appeal process that your health plan provider or insurance company might reverse their earlier denial. However, if that is not the case then in California you have a right to have your claim reviewed by an independent body. Such an independent review can be incredibly helpful in getting your coverage denial changed but it is not something that you should automatically consider since it is not a prerequisite for seeking court intervention because of the bad faith denial. In some circumstances, it can be more efficient and beneficial to a person with a denied coverage claim to skip the independent review stage and simply file a lawsuit to get the coverage that they deserve. It is for this reason that if you have completed the internal review process and your denial was not reversed then you should contact a lawyer that specializes in bad faith health insurance to get advice as to whether an external review is the right path to take for relief.

If after consultation with an attorney, you decide that the best move for you would be to seek an external review then you must determine the proper entity from which you should seek the review. In California, the proper entity is determined by the type of coverage that you have. If you are member of a managed health care plan then you will seek a review from the Department of Managed Health Care (“DMHC”). Whereas, if you are covered by a health insurance company then you can seek a review from the California Department of Insurance (“CDI”). Both the DOI and the DMHC have similar appeal procedures.

After you determine whether your claim is regulated by the DMHC or the CDI, then you should visit the website for the particular agency that governs your claims’ external appeal. The DMHC website can be found at: http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.aspx. You can also call the DMHC at 1-888-466-2219. The website for the CDI is <http://www.insurance.ca.gov/0100-consumers/0020-health-related/0010-consumer-provider-complaints/>. You can also reach the CDI by calling them at 800-927-HELP (4357). Both the DHMC and CDI have detailed information for how to file a complaint for an external appeal but generally the information that you provide to them will mirror the information and documents you provide to your insurance company or health plan provider when you seek an internal appeal.

Step 7:

Seeking court intervention.

If the external appeal does not result in a reversal of the coverage denial or if you decide to skip the external appeal then you also have the choice of filing a lawsuit against your insurance company or managed health care provider. The upside to a lawsuit is that it puts immediate pressure on your insurance company or managed health care provider. Insurance companies or managed health care providers who might have ignored you in the past will usually pay a lot more attention when a member has initiated a legal action. Further, a lawsuit can result in complete coverage for the medical treatment that you seek, in addition to the possibility of additional monetary awards due to the insurance company's or managed health care provider's bad faith in denying your claim. Most lawyers who specialize in bad faith health insurance coverage law take such cases on a contingency basis, meaning that they do not charge any money to a client but instead take a percentage of any recovery. As a result there is very little risk to you in bringing a lawsuit.

About Scott Glovsky

You've been harmed, injured or abused: call, it's free, and it might just change your life.

I fight for the justice you deserve


We may live in a "David vs. Goliath" world, but my firm is here to hold major corporations accountable for putting their bottom line profits ahead of peoples' lives. I am a skilled trial lawyer on a mission to make a real difference in my clients' lives, and change the system so that others will not needlessly suffer similar fates. My practice emphasizes civil trial law, including insurance bad faith, catastrophic personal injury, and health-related cases. We get justice for our clients and hold the wrongdoers accountable.

Cases & People That Make A Difference By Helping Others

Scott Glovsky is a nationally recognized victim's rights advocate. His cases have been covered by Oprah Winfrey, People Magazine, The Los Angeles Times, CBS Evening News, Michael Moore (Sicko) and hundreds of other media outlets.

Awards, Recognition & Achievements

Multiple multimillion Dollar Settlements & Awards
 President's Award of Merit – Consumer Attorneys' Association of Los Angeles
 California's Street Fighter of the Year – Trial Lawyer's Award
 Graduate of Gerry Spence's Trial Lawyer's College
 Southern California SuperLawyer (2006 – Present)
 Board Member – Consumer Attorneys of California

 <p>Law Offices Of Scott Glovsky</p>	<p>Scott Glovsky J.D. Cornell University Law School Graduate Pasadena Claremont Los Angeles Practicing locally since 1993</p>
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