BON SECOURS MERCY HEALTH

How to file a Medicare appeal*

If you disagree with a coverage or payment decision by Medicare, Medicare Advantage or other Medicare health plan or your Medicare drug plan, you can file an appeal.

Before you start ask your provider or supplier for any information to make your appeal stronger. If you're in a Medicare Advantage plan, other health plan or a drug plan, check your plan materials, or contact your plan, for details about your appeal rights. The plan must tell you, in writing, how to appeal.

You can usually find your plan's contact information on your plan membership card.

You can file an appeal if Medicare or your plan refuses to:

1. Cover a health care service, supply, item or drug you think Medicare should cover.
2. Pay for a health care service, supply, item or drug you already got.
3. Change the amount you must pay for a health care service, supply, item or drug.

You can also file an appeal if:

1. Medicare or your plan stops providing or paying for all or part of a health care service, supply, item or drug you think you still need.
2. Your plan's drug management program labels you as "at-risk" because you meet the Overutilization Monitoring System criteria. This means your plan limits your access to coverage for drugs like opioids and benzodiazepines.
3. You think your Medicare-covered services are ending too soon.

How do appeals work?

The appeals process varies depending on the coverage you have.

Learn more about Medicare the Medicare appeal process at **https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals**

**Medicare.gov*

BON SECOURS MERCY HEALTH

How to appeal an insurance company decision*

If your health insurer refuses to pay a claim or ends your coverage, you have the right to appeal the company's decision and have it reviewed by a third party. Insurers have to tell you why they've denied your claim or ended your coverage. There are two ways to appeal:

1. **Internal appeal:** You may ask your insurance company to conduct a full and fair review of its decision. If the case is urgent, your insurance company must speed up this process.
2. **Independent third-party review:** This is also called an external review. External review means that the insurance company no longer gets the final say over whether to pay a claim.

Internal appeal

Your provider has filed a reimbursement claim for the costs of treatment or services, but your health plan denies the claim. Your insurer must notify you in writing and explain why:

- Within 15 days if you're seeking prior authorization for a treatment
- Within 30 days for medical services already received
- Within 72 hours for urgent care cases

To file an internal appeal, you need to:

- Complete all forms required by your health insurer. Or you can write to your insurer with your name, claim number, and health insurance ID number.
- Submit any additional information that you want the insurer to consider, such as a letter from the doctor.
- The Consumer Assistance Program in your state can file an appeal for you.

You must file your internal appeal within 180 days (6 months) of receiving notice that your claim was denied. If you have an urgent health situation, you can ask for an external review at the same time as your internal appeal. If your insurance company still denies your claim, you can file for an external review.

What kinds of denials can be appealed?

You can file an internal appeal if your health plan won't provide or pay some or all of the cost for health care services you believe should be covered. The plan might issue a denial because they believe:

- The benefit isn't offered under your health plan
- Your medical problem began before you joined the plan
- You received health services from a health provider or facility that isn't in your plan's approved network
- The requested service or treatment is "not medically necessary"
- The requested service or treatment is an "experimental" or "investigative" treatment
- You're no longer enrolled or eligible to be enrolled in the health plan
- It is revoking or canceling your coverage going back to the date you enrolled because the insurance company claims that you gave false or incomplete information when you applied for coverage

**Healthcare.gov*

How to appeal an insurance company decision*

What do I need for my appeal?

Keep copies of all information related to your claim and the denial. This includes information your insurance company provides to you and information you provide to your insurance company like:

- The Explanation of Benefits forms or letters showing what payment or services were denied.
- A copy of the request for an internal appeal that you sent to your insurance company.
- Any documents with additional information you sent to the insurance company (like a letter or other information from your doctor).
- A copy of any letter or form you're required to sign, if you choose to have your doctor or anyone else file an appeal for you.
- Notes and dates from any phone conversations you have with your insurance company or your doctor that relate to your appeal. Include the day, time, name, and title of the person you talked to and details about the conversation.
- Keep your original documents and submit copies to your insurance company. You'll need to send your insurance company the original request for an internal appeal and your request to have a third party (like your doctor) file your internal appeal for you. Make sure to you keep your own copies of these documents.

How long does an internal appeal take?

- Your internal appeal must be completed within 30 days if your appeal is for a service you haven't received yet.
- Your internal appeals must be completed within 60 days if your appeal is for a service you've already received.
- At the end of the internal appeals process, your insurance company must provide you with a written decision. If your insurance company still denies you the service or payment for a service, you can ask for an external review. The insurance company's final determination must tell you how to ask for an external review.

What if my care is urgent and I need a faster decision?

In urgent situations, you can ask for an expedited appeal and also request an external review even if you haven't completed all of the health plan's internal appeals processes.

A final decision about your appeal must come at least within 4 business days after your request is received. This final decision can be delivered verbally, but must be followed by a written notice within 48 hours.

What kind of decisions can go to external review?

- Any denial that involves medical judgment where you or your provider may disagree with the health insurance plan
- Any denial that involves a determination that a treatment is experimental
- Cancellation of coverage based on your insurer's claim that you gave false or incomplete information when you applied for coverage

Where can I find more information about the process for external reviews?

https://www.healthcare.gov/appeal-insurance-company-decision/external-review/

BON SECOURS MERCY HEALTH

18601BSMSHT (3-25)