QUESTIONS TO CONSIDER WHEN YOUR HEALTH PLAN PROCEDURE / TREATMENT IS DENIED

- ☐ What type of insurance plan do I have (self funded, fully insured plan – group or individual plan, Medicare, etc.)?
- ☐ Does my health plan have a process to appeal denials of service and/or claims (bills)?
- ☐ Is the service / claim denied a covered benefit under my health plan? If it is not a covered benefit do I have any appeal rights under my plan?
- ☐ Does my health plan have to provide me with a written denial, including a specific reason(s) for the denial?
- ☐ What are my health plan appeal rights? Are my rights listed in my Evidence of Coverage and/or member handbook?
- ☐ What does my health plan consider an appealable issue(s)?
- ☐ How long do I have to file an appeal with my health plan?
- ☐ Can I request a faster appeal if I feel that waiting could seriously jeopardize my life, health, or ability to regain maximum function?
- ☐ If my appeal result is not in my favor, how many appeals do I have available with my health plan?
- ☐ Who within my health plan reviews my appeal (Consumers, Health care personnel, Medical Director, etc.)?
- ☐ Is my appeal completed via mail/telephone, or do I have the opportunity to personally attend an appeal hearing? May I take a representative(s) with me to the appeal?
- ☐ What state and/or federal law(s) apply to my rights regarding my insurance appeal?
- ☐ After my appeal, when will I receive a written decision from my health plan?

Created October, 2000 Office of the Governor, Consumer Health Assistance