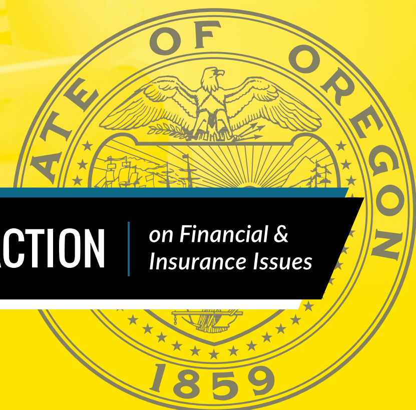
Consumer Guide to

Health Insurance Appeals



Oregon Division of Financial Regulation

About the Oregon Division of Financial Regulation

The Division of Financial Regulation protects consumers and regulates insurance, depository institutions, trust companies, securities, and consumer financial products and services. It is part of the Department of Consumer and Business Services, Oregon's largest consumer protection agency.

We regulate:

- Banks and credit unions
- Check cashing
- Debt management services
- Financial and investment advisors
- Insurance industry
- Mortgage industry
- Money transmitters
- Pawnshops
- Payday and title lenders
- Securities

We make sure that:

- Your insurance companies, banks, and credit unions are financially sound
- You are treated fairly
- Your insurance claims are handled promptly and accurately and the companies honor their policies
- All financial, insurance, and mortgage professionals are held to high standards
- Insurance rates not too high, not too low, and appropriate for the benefits being provided

We do this by:

- Investigating consumer complaints
- Analyzing and monitoring financial and insurance institution finances
- Reviewing all insurance policies before they are sold in Oregon
- Licensing companies and professionals
- Registering securities and other investment vehicles

Are they licensed? Whether you are considering an exciting new investment, getting ready to buy insurance, or applying for a payday or title loan, always be sure to check to make sure the individual or company you are working with is licensed.

Call us for help

Consumer Advocacy Unit 503-947-7984 or 888-877-4894 (toll-free)
You have the right to seek assistance from the Division of Financial Regulation at any time.

Visit our website

The Oregon Division of Financial Regulation's website includes all of our publications as well as other useful information for consumers. You can file a complaint against an insurance company or agent, check to see if an insurer is authorized to do business in Oregon, and find out if your insurance agent is licensed in Oregon. Our Web address: **dfr.oregon.gov.**

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Introduction

This guide will help you understand your appeal rights when you get a denial from your health insurance company.

As a result of federal health care reform, many of the changes to appeal rights started in mid-2011 although insurance companies did not have to make changes to all plans. Grandfathered plans (those that existed before March 23, 2010, and meet other criteria) are exempt from the new requirements. Talk with your health insurance company to find out how to appeal when your plan is grandfathered.

Ask your insurance company if you need any forms to file your appeal. Send your completed appeal letter or forms (if required) directly to the company.

For help understanding appeals, call our Division of Financial Regulation consumer hotline at 1-888-877-4894 (toll-free). Select the prompt to speak with a Life and Health advocate.

Where to start

Appeals generally have three phases:

1. Denial of request for service or payment
2. Internal appeal to your health plan
3. External appeal to an independent reviewer (for certain denials)

To know what appeals process to follow, answer these questions:

- What kind of insurance do you have?
- Do State of Oregon or federal officials regulate your plan?
- Is your plan a new plan (non-grandfathered) or an old plan (grandfathered)?
- Is your denial a "pre-service" issue, meaning you have not yet received the services?
- Is your denial a "post-service" issue, meaning you have received the services and may be receiving a bill?
- If it is a pre-service issue, is it urgent? Urgent means that your health may suffer if you do not receive the service.

All insurance companies have avenues to resolve issues without having to appeal. When in doubt, ask your health plan to re-evaluate the denial.

Your health plan **cannot** drop your coverage or raise your rates because you ask it to reconsider a denial. You are allowed to ask for an appeal – it's your right.

You do not have to pay for the appeal.

You can ask to continue to receive services during the appeal but if the denial is not overturned, you will have to pay for those services.

Independent review organizations ruled in favor of Oregon consumers in 34 percent of appeals made from 2008 through 2010.

Step 1: Identify the source of your insurance coverage and the issue

Where do you get your coverage?

Coverage source	Type of plan
Do you and your family have insurance through your employer?	If yes, then you have a group plan
Do you have insurance through a public program? *For example: Medicare, Oregon Health Plan, Healthy Kids, or another kind of state or federal program?*	If yes, then you have a government-sponsored plan
Do you have a policy that you or a family member purchased directly from an insurance company or the Health Insurance Marketplace?	If yes, then you have an individual plan

Note: Not all types of plans are required to provide an appeal process. You may have something other than a comprehensive health policy or a health benefit plan. For example, you might have a long-term care policy or a Medicare policy or disability policy. Contact the insurance company of the policy for appeals information.

What kind of denial did you receive?

Chances are you received a denial from your health insurance company for one of these reasons:

Your health insurance company:

- Refused to pay for medical services or care you already received.
- Denied approval for treatment or medical services you are currently receiving or for treatment your doctor thinks you need.
- If you have been denied for an urgent medical need, you may qualify for a quicker or "expedited" appeal.

If you were denied for another reason, call us at 1-888-877-4894 (toll-free) to see if your situation qualifies for an appeal.

Read the denial to learn:

- The specific reason for the denial
- The plan provision that supports the decision
- What the plan needs to reverse its initial ruling
- What your plan's appeals and grievance process is and the deadlines
- Where to send a formal appeal

Is your medical situation urgent?

If you have received a denial for a pre-service and your doctor believes your situation is urgent, your health insurance company may review your appeal faster than if it's not an urgent medical situation. This is called an expedited appeal. These could be handled by the insurance company or sent for an external review by an Independent Review Organization (IRO). IROs are discussed in detail later in this guide.

You can request an expedited appeal if you:

- Are currently receiving or you were prescribed to receive medical services or treatment; and
- Have a situation that is described as urgent by your doctor. Urgent means your doctor believes a delay in getting these services:
- Could seriously jeopardize your life or overall health, or your ability to regain maximum function.

You cannot file an expedited appeal if you:

- Already received the services or treatment and your health insurance company denied the claim, or
- Your situation is not urgent.

Who decides if your situation is urgent?

Your doctor or medical provider will decide if your situation is urgent.

How do you file an urgent or expedited appeal?

You or someone you have authorized to speak for you can call your health insurance company to file an appeal. You may file an urgent or expedited appeal verbally or in writing. Your health plan may respond with a verbal decision; but must put that decision in writing within 72 hours of receiving your request. If your appeal qualifies for review by an independent review organization, your insurer may not require that you complete an expedited internal appeal before beginning an expedited independent review.

If you need to file an urgent or expedited appeal, we suggest you or someone or your behalf (including your medical provider) immediately call your health insurance company.

Is your denial intentional or is it just a billing error?

If you receive a denied claim, you should first look to see if it is because of a billing error. Re-read the paperwork or materials your health plan sent. These are called Explanation of Benefits (EOB) statements. Confirm that:

- You (or a covered dependent) made the visit to the doctor or medical provider.
- Make sure the covered person, the doctor, and the health insurance company are listed.
- Check to make sure the doctor or medical provider billed your health plan correctly:
  - Are the charges correct? You may need to contact your provider's billing staff to determine whether the codes used to bill your plan match the services you received.
  - Is the date or dates of service correct?

If any of the details listed above are not correct, or you aren't sure what something means on your Explanation of Benefits, call your doctor or medical provider's billing office. Ask your provider to send you an itemized copy of your bill. (This is helpful in determining what was and was not paid for.) Ask them to explain your bill.

If the billing office tells you everything was billed correctly and you believe your health insurance company should have paid the bill, read Billing Errors on the next page for further information and instructions. You may also call our Consumer Advocacy consumer line at 1-888-877-4894 (toll-free). We will help you decide if you need to file a complaint with our office, file an appeal with your health insurance company, or both.

Limited appeal time is 180 days from the Date of Determination. Read the appeal rights in your denial letter for specifics.

Keep detailed records

Before you contact anyone, create a log to document:

- The type of contact you made, including the telephone number
- The date
- Who you talked to
- What was said

One reason to keep detailed records is that insurance companies may honor their mistakes.

If you received incorrect information from an insurance company's customer service representative, the company will verify that information. The company may honor that mistake – but only on past denials. It will not make the same decisions in the future once it provides the correct information.

Billing errors

If you think a billing error occurred, ask your doctor's office for details about the Current Procedural Terminology (CPT) or treatment code.

Sometimes valid disputes occur about treatment codes that doctors and other medical providers used to bill the health insurance company. Generally, health insurance exclusions don't refer to CPT codes. They refer to specific treatments and diagnoses. If a mistake was made, ask customer service to send you, in writing, how the correction will be made.

If you think the codes don't fairly represent the treatment you received, you can ask your doctor to re-bill the insurance company using the correct code and include your medical records for that visit.

Network

If your claim was denied because the doctor was out of network, you will have a greater chance to win your appeal if you can prove the plan's network had:

- No providers with the specialty you needed
- Very long wait times for the in-network providers
- No providers in your surrounding area

Mistake by your plan

- Prove you or your medical provider followed the rules under your health plan.
- Prove the denied treatment falls in a gray area within the plan's covered services. If it is not explicitly excluded, you could reason your plan should pay for it.

If all else fails, sometimes just asking your health plan for an exception can help your case.

What does your plan cover?

Your insurance policy should explain:

- Your health care benefits and any limits on the number of times you can use a specific benefit (for example, some plans cover only 10 visits per person, per year to see a chiropractor).
- Details about co-pays – that is, cost-sharing with your insurance company (Example: You may have a co-pay of $20 each time you visit the doctor). Remember, for new (nongrandfathered) health plans, there is no longer any cost sharing for many preventive services if they are performed by an in-network provider.
- The deductible, if any, that must be met before the plan will start to pay for medical care received.

- The exclusions or limitations to the policy.
- How the policy defines medical necessity and experimental or investigational treatment.
- The benefits that require preauthorization (advance permission) from your health plan, and how to get that approval.
- How to appeal decisions made by your health plan.
- The medical providers you can use.
- How the plan pays for services from an out-of-network provider.

Note: If you have group health insurance coverage through an employer, it is generally the employer's responsibility to provide you a copy of the plan or tell you where to find plan information online.

Before you decide to file an appeal, read:

- Your covered benefits in your plan's benefits booklet.
- What your health plan will not cover. You will find this in the exclusions and limitations section. (For some plans, you may need to contact your health plan directly for this information.)

Information about your benefits

Make sure you have the most recent copy of your plan's benefits booklet, which should include the specific exclusions and limitations to your plan.

Consider filing a complaint with the Division of Financial Regulation

Call our consumer hotline at 1-888-877-4894 (toll-free). Discuss your case with an insurance advocate.

Ask for a copy of everything your plan used for the denial

- Search for any missing information in your file that supports paying the benefit.
- Ensure any clinical research you use is current. Ask your doctor for guidance. Do your own research at www.pubmed.gov.

For canceled or rescinded coverage

Insurance plans must provide you with written notice at least 30 calendar days before they can rescind your health coverage.

Note: A health plan is allowed to rescind a policy only for fraud or intentional misrepresentation.

Failure to pay premiums

- Avoid making late premium payments. If you fail to pay your insurance premiums, your health plan might grant you a one-time exception if your payment is late, but this is not required. Be aware the company typically will not allow a second late payment and will cancel your policy.

Canceled COBRA

- Your employer can cancel your COBRA coverage if you don't make your premium payments. Federal COBRA law doesn't require your employer to notify you that it has canceled your coverage.
- If you think a former employer canceled your COBRA coverage in error, contact the **U.S. Department of Labor (DOL):** 1-866-444-3272 (toll-free).

Step 2: Internal appeal process

Preparing to appeal

Use the Appeal Worksheet to gather information. Note the following:

- Your contact information (name, mailing address, phone number)
- Contact information for the person representing you, if applicable (such as an attorney, parent or guardian, provider, or person who is acting as your attorney)
- Name of the company or group providing the health plan policy number and, if it applies, claim numbers
- If your plan is through your employer, the name and location of your employer
- Names of doctors or providers who provided care or who gave an opinion or recommendation

Documents you may want to gather to help you with your appeal:

- Your most current benefits booklet.
- All documents related to the situation you are appealing.

- Ask what criteria the insurance company used to base its decision on and to send you a copy of that document. You can share this with your doctor so the doctor can provide the information needed for the service to be covered.
- Any explanation of treatment or services from your medical provider's office.
- Any denials (also known by your health plan as adverse benefit determinations).
- Any research to support your opinion that the denial should be overturned (you can ask your insurance company's customer or membership services department for the criteria they used as the basis of your denial).

Getting your documents

Gather all medical records and other supporting documents early on in the appeals process. Ask your doctor to help you gather the information you need. If you ask the insurance company for the criteria it used in denying your claim, you can give that to your doctor when you ask for help.

When you think your health plan should pay for coverage – appeal

Keep detailed medical records. Most appeals require you to prove something, and it can be a lot easier to do that if you have good records. Document everything.

- Stick to the facts and emphasize objective medical information over discussing your emotions.
- If someone told you they would get back to you by a certain day and they didn't, call them.
- If something is not clear to you, ask questions until you understand it.

- When you need to send documents to your provider or your health plan:
  - Send copies instead of the originals.
  - Send documents as certified mail, so you will know when they are delivered. (Certified mail means someone has to sign for it, and you can see who signed for it and when.)
- Your portion of the cost of medical care can be negotiable.
  - Ask your health care provider to accept the amount your health plan will pay for a procedure as full payment.
  - If a health plan won't pay at all, try to agree on a price for you to pay out of pocket.

Ask your medical provider to change your prescription if it is not covered by your plan.

Preparing to appeal

1. You file your appeal with your health plan in writing (your health plan may provide a form). If you are requesting an expedited appeal due to a clinically urgent situation, you may file your appeal verbally or in writing.
2. Depending on the laws that regulate your plan, your decision could come back in 72 hours if it is urgent, or 30 days otherwise.
3. If the decision is not reversed on the first appeal, and if you have your plan through an employer, your carrier may allow a second level of internal appeal.

Who regulates your appeals process?

Generally, state or federal laws and regulations establish your appeal rights and officials from these governments regulate the process. However, some plans are allowed to set their own rules. Here are guidelines as to who to contact to learn more about your appeal rights.

Individual: If you buy an individual insurance policy (meaning you don't get coverage through an employer) directly from a company, the Division of Financial Regulation likely regulates the plan and its appeals process. Contact an advocate: 1-888-877-4894 (toll-free).

Group: If you have group coverage through an employer, ask your plan administrator or your human resources department about the appeals process and who regulates appeals. It could be state or federal agencies or a plan that doesn't follow state or federal requirements and is allowed to establish its own process. Call an advocate: 1-888-877-4894 (toll-free).

Medicare: If you have Original Medicare (Parts A and B), a Medicare Advantage Plan, or Medicare prescription drug coverage, Medicare is the contact. Call Medicare at 800-633-4227 (toll-free) or visit the **Medicare Appeals and Grievances** website. You can also contact a state program that counsels people with Medicare, the Senior Health Insurance Benefits Assistance Program (SHIBA): 800-722-4134 (toll-free) or visit the website shiba.oregon.gov.

Medicare Supplement policies (Medigaps): The Division of Financial Regulation regulates Medicare Supplement plans. Call 1-888-877-4894 (toll-free).

Oregon Health Plan: Contact a caseworker.

Military personnel with Tricare: Call 1-253-572-2888 or 1-253-572-2350 or visit **www.tricare.mil/contacts/**

Stay in contact with your medical provider

If you will need a letter from the medical provider, confirm that he or she will be available to write it (and not away from the office). Provide your medical provider with a copy of the contract provision the health plan is using for the denial. You should also give your medical provider any letters

or memos the company sent you for denying the claim. This helps your medical provider focus his or her statements on issues related to your appeal.

- If time allows, ask to proofread the letter your doctor writes on your behalf. Make sure the letter addresses the reasons your health plan is denying the claim. Some letters aren't specific enough or sometimes contain errors. Successful appeals have persuasive letters from doctors.
- Gather all medical records and other supporting documents as early in the process as you can. If your appeal moves on to the external appeal level, you will want to have everything in your possession. That stage of the appeal process has a shorter turnaround time for a decision. You have the ability to send any case information to the independent review organization within one week.

If your health plan requests more time to consider your claim, you don't have to grant it. If your health plan doesn't return a final decision to you in the time allowed, you can move on to the next level of appeal.

Successful appeals

Appeals are more likely to go in your favor if they:

- Contain easy-to-prove facts
- Are to the point and contain only necessary information
- Are complete
- Are submitted within the time allowed by your plan
- Show you were active and persistent in your interactions with your health plan and your doctor

For a denied claim

- Rule out the possibility of a billing error.
- Call your medical provider's billing office first (document the call on your records log).
- Tell them you received notice of a denied payment in the mail from your health plan.
- Ask why your health plan denied payment for a visit to their office. You will be told it is either a billing error or a claims processing error - both of which should be cleared up by your provider's office. If it's not a billing or processing error, you will need to appeal in order to overturn the denial.

Make sure you have a copy of the current plan summary and exclusions and limitations.

You may need to call your health plan to find out where you can find this information on the plan's website, or ask to have it mailed to you.

Common Traits of Unsuccessful Appeals

Appeals are less likely to go in your favor if they are:

- Hard to read
- Excessively long and include unnecessary details
- Highly emotional and include feelings of frustration, pain, or anger rather than facts
- Incomplete
- Are written with hard-to-read handwriting
- Submitted past the deadline

Why consumers lose appeals

Missing information

- You don't have a letter from your doctor detailing why a procedure is medically necessary.
- Your letter to the health plan doesn't address your specific medical issues or the plan's language.
- You didn't provide documentation of treatments you tried before the treatment your doctor is currently prescribing.

- You didn't provide information about something the health plan considers relevant and wants to investigate.
- You didn't include evidence showing how the medical community considers your treatment as standard practice.

Not in the contract

- You were prescribed or received treatment, or a prescription, that is specifically not covered by the plan.
- You didn't pay your premium on time and your policy was canceled. The health plan will not pay for any medical services after your policy was canceled.
- You disputed the contracted amount the health plan paid to your provider. You cannot ask the plan to pay more or less to a provider than the contract allows.
- You asked about a hypothetical situation. Unless your doctor or other provider is required to get prior authorization for a treatment they determine to be medically necessary, the health plan is not required to tell you how it would process a claim in advance. The health plan is required to provide information on common services, procedures, and costs.
- Things at the discretion of the carrier, such as a request that a prescription be recategorized so that it costs less.
- Your medical provider's billing office can make mistakes. Your health plan can respond only to information provided by your provider. If your provider used the wrong CPT code, or did not get prior authorization, as the plan requires, then your health plan does not have to pay your claim. Your provider may be responsible for their mistakes especially if they are an in-network provider.

Employer and Employee Issues

Eligibility – For example, when an employer tells the group health plan provider that a worker no longer qualifies for coverage as of a certain date, and the health plan denied any claims that came in for that worker after that effective date.

Late premium payment – When an employer fails to pay its portion of the premium to the health plan and the health plan cancels coverage for all the employees on the plan.

You cannot fix these last two issues by filing an appeal. You can file a complaint with the U.S. Department of Labor.

United States Department of Labor - Employee Benefits Security Administration.
Phone: 1-866-444-3272 (toll-free).

What if you have a doctor bill because of a denial?

If you are appealing the denial of services already received, you might get a bill from your doctor. While awaiting your appeal decision, you can do any of the following:

- Ask the medical office if you can delay paying it until you know the outcome of your appeal. Ask the medical office to not send the bill to collections
- Set up a payment plan (to avoid having the bill sent to collections)
- Pay the bill and get reimbursed if you win your appeal.

Step 3: External review process

What happens if your appeal is denied after all other internal levels of appeal have been exhausted?

You may have the right to proceed to an external review. The external review process is designed to have your case reviewed by a third party unaffiliated with your insurer. When you have applied for an external review your insurer will notify the Division of Financial Regulation of your request for an external review. The division will randomly assign your case to an independent review organization (IRO) contracted with the division to provide external reviews. The IRO assigned to your case will have one or more medical professionals review all documents and issue a binding decision to either overturn the case in your favor or uphold the insurer's decision. In some circumstances, the IRO may rule that the appeal does not qualify for a full external review and will issue an ineligibility letter.

The external review process is a document review process; once the IRO has reviewed your case, it will issue a final case synopsis letter detailing the outcome of your case. There are no hearings during the external review process.

Expedited external review

A standard External Review will be completed within 30 days.

If you have a medical need in which the standard 30-day timeline would jeopardize your health or ability to regain maximum function, you have the option to request an expedited review. If your case is expedited, the IRO will make its binding decision within 72 hours.

Preparing to appeal through the external review process

To request an external review you will file your appeal with your health plan in writing, along with a HIPAA release form allowing the insurer to provide your medical records to the independent review organization. You have 180 days after you receive your final benefit determination letter to submit your request for an external review. Your case will not qualify for a review if you exceed this timeframe.

To request an expedited review you will need to supply the written request for an external review, the HIPAA release form. Also, your provider needs to certify in writing and provide supporting documentation that the ordinary time period for external review would seriously jeopardize your life or your ability to regain maximum function.

Your insurer is obligated to submit documentation to the assigned IRO for review. You have seven days after receiving your case assignment letter from the division to supply information directly to the IRO for review. The division recommends you gather any and all information you want reviewed before starting your external review request as it may take time for you to receive the medical documents.

External review criteria

Each case will be screened by the selected IRO to determine if it qualifies for an external review. While your insurer may give you advice on whether it believes your case does or does not qualify for a review, by state law, your insurer must submit your request to the Division of Financial Regulation for assignment. Only the IRO has the

ability to determine if a case qualifies for a full external review. A case qualifies for an external review if it meets one of the four criteria below:

A. Whether a course or plan of treatment is medically necessary.

B. Whether a course or plan of treatment is experimental or investigational.

C. Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225.

D. Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

If your case does not qualify for a full external review, the IRO will issue an ineligibility letter to you with an explanation as to why your case was not able to be reviewed in full.

Document submission and review

When your case is assigned to an independent review organization, the Division of Financial Regulation will send you, via mail, your case assignment information. This letter will detail the contact information for the selected IRO and will provide you with a timeline for you to submit documentation for the IRO to review.

Determination

After review all documentation the assigned independent review organization (IRO) will issue a final determination in writing. If you had an expedited review, the IRO will call all parties and issue a final determination in writing.

The IRO's decision is binding to the health plan. If the case is upheld in the insurer's favor you may seek legal guidance as a final option.

For information and questions regarding the external review process please call the Division of Financial Regulation at 503-947-7268

Tools

Use the forms on the following pages to help you document your appeal process.

Filing a formal complaint against an insurance company or agent

You may want to file a formal complaint against an insurance company or agent. A copy of the complaint is sent to the insurance company. A response from the insurance company or agent must be received at the Division of Financial Regulation within 21 days. A consumer advocate will determine what further actions, if any, will be taken. The Division of Financial Regulation will forward a copy of the insurance company's response to you.

Communication Log

It is important to keep a written record of every letter, phone call, e-mail, and conversation about your appeal. Try to write down each contact right away, while the details are fresh.

EXAMPLE

Date	Contact type	From	To	Summary
3/4/2011	Letter	AETNA	Me	Claim for my MRI Denied
3/7/2011 (10 AM)	Phone call	Me	Dr. Wilson's office. Spoke with Carol T.	Called to ask if claim was billed properly. It was. Told Dr. I want to appeal the denied payment.
3/08/2011	Phone call	Me	Aetna. Spoke with Ruth Johnson	I asked how long I would have to file an appeal. Was told 180 days from the date of original denial (3/1).

Date	Contact type	From	To	Summary

Appeal Worksheet

Information about your plan:

1. Type: ☐ Individual ☐ Group ☐ Other ____________________
2. Insurance provider name: ____________________
3. Policy no. (if applicable): ____________ Group no. (if applicable): ____________

   ID no.: ____________ ☐ New plan (nongrandfathered) ☐ Old plan (grandfathered)
4. Who regulates it? ____________________
5. ☐ Coverage still effective ☐ Coverage terminated If terminated, date of termination: ____________
6. Type of health plan: ☐ HMO ☐ PPO ☐ Traditional indemnity (fee-for-service plan)
7. Based on the information above, can you see out-of-network providers? ☐ Yes ☐ No

   If yes, how much is the co-insurance, co-pay or deductible? ____________
8. Would you need a referral from a primary-care provider for a specialist? ☐ Yes ☐ No

   If yes, are there restrictions to which specialists you can see (e.g., in-network vs. out-of-network)?

   ☐ Yes ☐ No If yes, restrictions are: ____________________

   ____

Information about your denial:

1. ☐ Pre-service claim ☐ Post-service claim

   If it is pre-service, is it urgent? ☐ Yes ☐ No
2. Date of the denial: ____________ How long do you have from this date to appeal? ____________
3. Claim no.: ____________ Diagnostic code (if known): ____________
4. Treatment or service that needs to be covered: ____________________
5. Do you have evidence to prove that it should be covered? ☐ Yes ☐ No
   (e.g., page # of EOC, doctor's recommendation notes, notes documenting prior health history)

   Research that shows how treatment is necessary or cost-effective in the long run? ☐ Yes ☐ No
6. Contact information for the recipient of the appeal and key dates for the various stages of the appeal:
   (e.g. list dates when one should expect a response from company).

   ____

   ____
7. Is your issue one that is listed in the exclusions and limitations (Evidence of Coverage) that the health plan will not cover? ☐ Yes ☐ No

Medical provider information:

Medical provider's name: ____________________

Provider's service/treatment address: ____________________

Provider's phone number: ____________________

DCBS Consumer and Business Services

440-2971 (9/11/COM)

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