



Sample Denial Appeal Letters

Effectively Resolving and Preventing Denials

Explanation

One key to effectively appealing denials received from third-party payers is creating persuasive, fact-based appeal letters. Excellent appeal letters may result in denials being overturned without the need for additional dialogue or action on the part of hospitals' appeals staff, allowing staff members to utilize their time in completing other appeal-related tasks.

As the following sample appeal letters show, citing specific research and state or federal statutes is an integral part of effectively appealing denied claims. While including pertinent documentation and explanation of patients' treatment is also important, it is often necessary for providers to clearly indicate those laws that motivate insurers to re-examine their denial of payment.

The sample letters include an appeal for a claim denied because the insurer found hospital charges to be above the usual, customary, and reasonable rate, and an appeal for a claim denied due to untimely filing. The last letter is one that requests payment and is sent to an insurer since the insurer has not responded to previous appeals.

Reason for Denial: Charges Exceeded Usual, Customary, and Reasonable Rate

{Date}

{Insurance Name}
{Insurance Address}
{City, State Zip}

RE: Patient Name: {Last, First Initial}
Member ID: {123456789}
Date of Service: {mm/dd/yy - mm/dd/yy}
Hospital ID: {123-456789012}
Hospital Name: {Hospital}
Total Charges: {\$}
Claim No: {123456789}

{Dear Plan Administrator/Director of Claims/To Whom It May Concern}:

We are in receipt of the benefit payment for the above referenced claim.

It is our understanding that benefits were significantly reduced due to your determination that our charges have exceeded what your organization has found to be the usual, customary and reasonable rate for certain procedures or items on the bill referenced above.

We do not believe the reduction is justified. Our charges are altogether well within the level of usual, customary and reasonable charges. This letter represents an appeal to allow billed charges and modify your reimbursement accordingly. As you are likely aware, provider reimbursement rates are typically adjusted by insurers based on the usual, customary and reasonable treatment charges for that specialty and the geographical region where that service was provided. Further, many states, including {STATE}, and federal disclosure laws require insurers and administrators to advise beneficiaries and providers as to how the reimbursement rate formula is determined.

{OPTIONAL}

We intend to inform our patient and your insured that {NAME OF INSURANCE COMPANY} insurance carrier is basing its decision not to reimburse or to reduce reimbursement without providing any justification. As a result of your reimbursement policies, your insured is left with bearing an increased financial burden. The charges on {PATIENT NAME} account are accurate. Our charges are fair and reasonable and we go to great lengths to ensure they remain fair and reasonable. Current statistics from the MEDPAR, a national database, indicates that {HOSPITAL NAME}'s charges are {PERCENTAGE} below the national average. Similar data compiled by {STATE HEALTH COMMITTEE}, a state agency, indicates that {HOSPITAL NAME}'s charges are {PERCENTAGE} below the Utah state average for hospital charges. Both of these sources are independent of {HOSPITAL NAME}.

{OPTIONAL}

We have never and do not currently engage in or adopt billing practices with the intent to take unfair advantage of our clients and or payers. Your reduction in payment suggests you distrust healthcare providers. In an effort to maintain our position as one of the most affordable healthcare organizations in {STATE} and in the United States, we continually review and compare our prices with facilities in the intermountain west to ensure that we remain competitive; we have found our prices to be below this region's average.

Based on this information, we request that the reductions be reversed and an additional payment be made.

We appreciate your prompt attention to this matter.

Sincerely,

{Name, Title}
{Department}
{Hospital}
{Phone Number}
{Fax Number}

CC:
{Patient Name}

Reason for Denial: Untimely Filing

{Date}

{Insurance Name}
{Insurance Address}
{City, State Zip}

RE: Patient Name: {Last, First Initial}
Member ID: {123456789}
Date of Service: {mm/dd/yy - mm/dd/yy}
Hospital ID: {123-456789012}
Hospital Name: {Hospital}
Total Charges: {\$}
Claim No: {123456789}

{Dear Plan Administrator/Director of Claims/To Whom It May Concern}:

This letter is to request immediate payment of the above referenced claim. According to your remittance advice dated {mm/dd/yyyy}, this claim was processed and denied due to the provider's failure to meet the applicable timely claim-filing requirement. Attached is documentation, which confirms our initial claim filing date of {mm/dd/yyyy}.

{ACCOUNT SPECIFIC INFORMATION – GIVE DESCRIPTION AND/OR INTERPRETATION OF FINDINGS WITHIN RELEVANT DOCUMENTS, CONTRACT PROVISIONS, STATE/FEDERAL LAWS, ETC. THIS MUST BE YOUR MAIN ARGUMENT}

The above information notwithstanding, we believe the claim above was filed in a timely manner and certainly as soon as reasonably possible. Any delay in {INSURANCE NAME}'s receipt and successful processing of this claim was not a result of failure to act, intentional mistakes or fraudulent actions on the part of the patient or the hospital.

If your review of our appeal and the attached information results in the claim remaining denied, please send our office a detailed explanation of your decision. Please include details showing why {INSURANCE NAME}'s ability to process this claim accurately was compromised due to the length of time between receiving the claim and the date of service.

We thank you for your time and prompt attention to this matter.

Sincerely,

{Name, Title}
{Department}
{Hospital}
{Phone Number}
{Fax Number}

CC:
{Patient's Name}

Enclosure(s)

Letter Requesting Payment and Response to Previous Appeal

{Date}

{Insurance Name}
{Insurance Address}
{City, State Zip}

RE: Patient Name: {Last, First Initial}
Member ID: {123456789}
Date of Service: {mm/dd/yy - mm/dd/yy}
Hospital ID: {123-456789012}
Hospital Name: {Hospital}
Total Charges: {\$}
Claim No: {123456789}

{Dear Plan Administrator/Director of Claims/To Whom It May Concern}:

On {mm/dd/yyyy}, our office mailed an appeal to the following address, {GIVE ADDRESS ON FIRST APPEAL}. That letter was sent via certified U.S. Post {CERTIFIED MAIL #} and our delivery receipt shows successful delivery occurred on {mm/dd/yyyy}. Our office is acting as the duly authorized representative of {Patient or Policyholder Name} and {Hospital Name}.

It has now been over 30 days without any written reply from your office. Therefore this letter represents a demand for immediate payment. Federal law and ERISA govern your operations, including adverse benefit determination review procedures. Please refer to 29 CFR 2560.503-1, or ERISA. ERISA is very specific in its rules for review procedures,

“...The plan administrator shall notify the claimant, in accordance with paragraph (i) of this section, of the plan’s benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant’s request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant’s request for review of the adverse determination.”

Our inquiries regarding your organization’s adverse benefit determination review procedure show you allow {NUMBER} appeals of any adverse benefit determination. Therefore, you are required to respond to either the first or second appeal within 30 days. You have failed to respond to our appeal within the timeframe allotted by Federal Law. The validity of your denial of the charges above is in question. As of today, your organization is in violation of Federal Law. Accordingly, this letter represents a demand for immediate payment or reply.

Sincerely,

{Name, Title}
{Department}
{Hospital}
{Phone Number}
{Fax Number}

CC:
{Patient’s Name}

Enclosure(s)