Tips to Help You Appeal a Denial From Your Managed Care Health Insurance Plan (MCHIP)

Each MCHIP has a specific process to resolve complaints, appeals, and grievances. Your Evidence of Coverage (EOC) and other plan documents outline the process and contain information on how to appeal a denial. If your MCHIP has denied something, such as authorization for services or payment on a claim, you can appeal. If you submit a written appeal to your MCHIP, they are required to respond in writing. You can also call your MCHIP and a representative will provide information to assist you. You can also call us at the Office of the Managed Care Ombudsman for assistance. Here are some tips to help you make an effective appeal.

Clearly state what you want to appeal and why. Identify the specific service or claim that you are appealing and if applicable include the date of service, provider, claim number and any other information that will help your MCHIP know what you are appealing. Determine if your appeal involves a medical issue, such as payment or authorization for services you believe were medically necessary, or an administrative issue, such as a benefit that was denied because your MCHIP states the benefit was not eligible for coverage.

Discuss the problem directly with your MCHIP. Contact a customer service representative and learn all you can about the issue you are appealing. If you have a denial letter, contact the individual identified in the letter as the point of contact. Take notes to include the date, name of the person you speak with, summary, and final outcome of your discussion. If the conversation indicates the problem will be solved, check back with your MCHIP if the problem is not resolved in a reasonable time.

Involve your treating health care provider. If your appeal involves denial of treatment your provider believes is medically necessary, ask your provider to contact your MCHIP and discuss the issue. Your provider can contact the MCHIP's medical management section to discuss the request. Such direct discussions often resolve the problem.

Submit a written appeal. If neither you nor your provider can resolve the problem over the phone, send a written appeal to your MCHIP. Carefully read your EOC and other documents to gather information that supports your position. Clearly explain why you believe your position is correct, and write in a business-like manner. Focus your argument on the facts that support your position. Specifically state why you dispute the decision, and if you have received a denial letter, address each reason for the denial in the letter. Provide specific information and concentrate on facts. Be sure to include your name, identification number, address, and telephone number.

Make a copy of your appeal before you mail it to your MCHIP, and consider using certified mail; return receipt requested to ensure your appeal is received and so you have proof as to when and by whom it was received.

Important: Many MCHIPs have a limited time period for you to appeal. If you do not meet this timeframe you may forfeit your appeal rights.

Follow up on your appeal. If you do not receive an acknowledgment within a few days, call your MCHIP and ask if they received your appeal. Follow any instructions included with any acknowledgment letter you receive and ensure you understand the next step in the appeal process. If you send your appeal via facsimile it is very important to call your MCHIP and ensure they received your appeal.

Understand and use the appeal process. The EOC and letters you receive from your MCHIP will contain an overview of the appeal process. Be sure to understand how many appeals you have under the MCHIP's procedures, and whether the procedure permits you to meet with the MCHIP to present your appeal in person. If your internal appeal is denied, you may be eligible for the Bureau of Insurance's External Review program. You can obtain information on the External Review program by contacting your MCHIP or the Office of the Managed Care Ombudsman.

Expedited appeals. If your appeal must be decided on an urgent basis, your MCHIP will modify the standard appeal process and render a decision on an expedited basis. These appeals usually involve medical necessity denials, such as pending medical treatment required for an urgent medical situation. You can obtain information on expedited appeals from your MCHIP or the Office of the Managed Care Ombudsman.

The Office of the Managed Care Ombudsman will assist you with your appeal. While we cannot file your appeal for you, we will assist you and ensure you understand the process and have access to all the internal appeals your MCHIP offers. We can also contact your MCHIP to clarify issues involved in your appeal and help you understand the issues involved in your appeal.

Contact Information

Office of the Managed Care Ombudsman
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