Appealing Your Insurer's Decision Not To Pay

If your health insurance company ends your coverage or refuses to pay a claim that you filed, you may have the right to appeal the decision and have it reviewed by a third party. Directions for filing an appeal are listed in the information your insurance company sent you when they denied your claim. For prescription drugs, an "exceptions" process is also available. To learn more about the exceptions process, visit **https://marketplace.cms.gov/outreach-and-education/know-your-rights.pdf** to read "Know Your Rights."

Steps for appealing your insurance company's decision

Your plan must notify you of their decision about your claim and explain why you were denied within a set amount of time (based on the type of claim you filed). They also have to let you know how you can appeal their decision. In most cases, you must submit your appeal request in writing.

You can request an urgent internal appeal or an expedited external appeal if the time needed for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function.

1. **Request an internal appeal**

   An internal appeal is the first action you can take. To ask for an internal appeal, you must file it within 180 days (about 6 months) of getting notice that your claim was denied or your coverage was ended. To file an internal appeal you must:

   - Complete all forms your health insurance company requires or write to your insurance company with your name, claim number, and health insurance ID number.
   - Submit any other information that you want the insurance company to consider when evaluating your appeal, like a letter from your doctor.

   Important: You may also file an urgent internal appeal in cases where you would be subject to severe pain that can't be managed without the care requested by a doctor who knows about your condition. Appeals involving urgent care claims can be made by phone to your insurance company.

2. **Review your insurance company's decision about your internal appeal**

   Your insurance company must provide you with a written decision at the end of the internal appeals process. In most cases, if your insurance company still denies you the service or payment for a service, or ends your coverage, you can ask for an external review. Directions for asking for an external review are on the insurance company's final decision letter.

3. Request an external review, if needed

If you decide to ask for an external review, you usually must file a written request within 4 months, but in some cases within 60 days, of the date your insurance company sent you a written decision. The notice your health insurance company sends you should tell you the specific timeframe in which you must make your request. You may appoint a representative (like your doctor or another medical professional) who knows about your medical condition to file an external review on your behalf.

- The information on your "Explanation of Benefits" (EOB) or on the final denial of the internal appeal by your health insurance company will tell you how and where to send your external review request.
- The external reviewer will issue a final decision. An external review either upholds your insurance company's decision or decides in your favor.
- You may also request an expedited external review if the decision involves a case concerning the admission, availability of care, continued stay, or health care service for which you got emergency services, but haven't been discharged from a facility.
- Your insurance company can't delay payment for the service if the decision's in your favor, even if it intends to seek judicial review or another remedy that may be available in some states.
- Standard external reviews are decided no later than 60 days after the request was received, and in most cases within 45 days.

Insurance companies in all states must participate in an external review process that meets the consumer protection standards of the health care law. Your state may have an external review process that meets or goes beyond these standards. If so, insurance companies in your state will follow your state's external review processes. If your state doesn't have an external review process that meets the minimum consumer protection standards, the state's plans and insurers must choose between one of two options for a federally administered external review. The external review can be conducted by an independent review that's contracted by the insurance company or by an external review program contractor administered by the Department of Health and Human Services (HHS).

More about urgent and expedited requests

You can file your internal appeal and external review at the same time if the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function. A final decision about your appeal must come as quickly as your medical condition requires. In most cases this will happen within 72 hours or less, but it won't take longer than 4 business days.

Getting help with your appeal

There are many resources available to help you with your appeal.

- Visit **HealthCare.gov/appeal-insurance-company-decision/**.
- Visit **LocalHelp.HealthCare.gov** to find help in your area. Your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help you, along with other local organizations.
- Call your insurance company's consumer hotline. A list of hotlines is available at **HealthCare.gov**.
- Get help and information about appeals and other Marketplace issues in your preferred language at no cost. To talk to an interpreter, call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- Appoint an authorized representative to help you. Your representative can be a family member, friend, advocate, attorney, or someone else who will act for you. This can be done several ways, depending on the type of appeal you're filing. In the case of an urgent care claim, a health care professional with knowledge of your condition may serve as your authorized representative.

CMS Product No. 11771
Revised September 2015