

If Your Health Insurance Denies You Coverage, Try This...

Health Advocate, an organization that helps people navigate the health care system, claims that most people who are denied health care coverage face these problems because of inadequate understanding of their policy or poor paperwork. I would like to know what you think. Does that match your experience?

Here's their advice.

Review the details of your insurance appeals process. Insurance companies are required to give you all the tools you need to properly make an appeal. There are certain time frames to appeal so make sure you act fast.

Make sure you have all your paperwork in order. Keep records of everything: the bills from your provider, your explanations of benefit, copies of denial letters, your medical records, letters from your provider, etc.

Contact your Human Resources Department. (If you receive coverage through your employer). HR Departments are often equipped to provide you with some direction and can translate the fine print of your policy.

Check your insurer's medical policy.

Ask your physician to review and utilize it to prepare a "Letter of Medical Necessity" to support your case. Your physician is your best resource in preparing a successful appeal.

Take detailed notes when you speak to the insurance company. Write down the time and date, length of the call, the name and title of the person you speak with, and all the details of the conversation. Make note of any follow-up activities and next steps by all parties.

Write down your argument. Make notes of exactly what happened, when and why. If you are seeking approval for treatment, note any supporting science, clinical evidence, expected benefits, etc. Be clear, firm and concise. Make it clear that you plan to pursue the appeal until it is resolved and the claim is paid or care is approved.

Keep on top of the insurance company. Many appeals take weeks, even months, so call often to check in on the status. And take notes of each call.

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An appeal may go through many levels.

All insurance companies are required by law to have an appeals process. And most of these have at least three levels. The first level appeals are usually processed and reviewed by the insurance company's appeals staff or by the insurance company's medical director responsible for the denial. The second-level appeals are reviewed by a medical director not involved in the original claim decision. And the third-level appeals are usually completed by an independent, third-party reviewer in collaboration with a physician who is board-certified in the same specialty as the patient's physician. If your appeal is elevated to the third level and the insurance company continues to deny your claim, you can then take your appeal to the state level. Contact your state's Insurance Department (contact information is usually found on your state government's website) for more information.

Seek professional help. If you believe you have a case but are physically unable to handle the appeals process, there are professional health advocacy organizations that can compile and submit the appeal on your behalf. Health Advocate, Inc. and Health Proponent are two of the advocacy industry leaders who can assign a personal health advocate to your case.

Notify your healthcare professionals.

If your appeal is successful, you will want to explain the situation to your healthcare providers as soon as possible to avoid any lapse in care or damage to your credit.