

“Medical Necessity Appeal Template”

I. Basics

When medical treatment is denied, you have the legal right to ask for an internal review by submitting an appeal letter. An appeal letter is an important step in getting the insurance agency to successfully cover the cost of a medical bill. The purpose of the letter is to formally request a change in an official decision that was made as a result of a bill that was previously submitted for payment.

Before you get started, have you researched your health insurance plan policy guidelines and enrollee policy exclusions to ensure service, treatment, or procedure you're requesting to appeal is covered? If so, you want to proceed with preparing your appeal letter.

To get started, there are a few steps that you should adhere to when writing your appeal letter.

II. Format

The Format demonstrates a quality structure for the overall flow of the appeal. The goal of the format is to create a request which is clear and concise. The format will allow an opportunity to establish the relationship between the provider and payer, thus bringing clarity while the reader understands the request. Most importantly, providing proper clinical documentation is key to the success of a strong appeal letter.

III. Before you start

Now that you are ready to start writing your letter, there are a few steps you should consider before you begin. Have you reviewed the correct address of the provider? Many hospitals, clinics, and agencies could have multiple addresses listed; however, your letter must be mailed to the correct mailing address.

Consider including the date of appeal submission. This is important because it determines a time frame for when an appeal can be filed in most cases. You might also want to know if the managed care plan allows a grace period for filing an appeal.

A managed care plan's denial letter may include instructions on how to appeal. Check the verbiage carefully to avoid possible errors without omitting pertinent information. Following their instructions will ensure we do not risk having our appeal request denied.

Lastly, be sure to track your letter before mailing and keep all receipts. As a result of this process, your letter will be able to serve as documentation that you made an appeal. Therefore, the healthcare plan will be expected to respond within a reasonable timeframe.

IV. The Body

The body of the letter should include the basics of any letter such as salutation, introduction, purpose, closing or conclusion, and signature. For our current assignment, we will focus on the purpose of the body of the appeal letter.

After you have included a brief introduction, proceed by including the reason for the denial. Afterward, make your request, or appeal, by stating what you desire to see as your outcome. To put it more simply, ask yourself what do you want? For example, you may want to state, "this is an appeal for payment in full as originally billed for Jane Doe's denied claim for outpatient care at Medical Center".

Again, review the instructions included with the denial letter to understand the requirements of an appeal process for specific major medical coverage. Some may require that you include Health Insurance Claim Number (HIC), Beneficiary Identifier Number (BI), etc.

Including details such as the name of the procedure, service, or treatment and your health plan will create a recipe for a successful appeal. If the customer has a medical condition, you want to consider making the addition to the appeal letter. Here's an example of an appeal letter below.

*Dear **Grievance and Appeals Administrator,***

Services for this claim were denied based on a procedure deemed experimental/investigational by xxxx.

Maternity Care and Delivery (CPT 99999) is a MEDICAL Obstetrical related condition. One of the approved diagnoses is Obstetrics National approved procedure and the American Academy of United States National governmental criteria for Maternal pregnancy and labor treatment is medically appropriate. In the case of the patient, a clinical order was provided. Thus, in this case, the procedure xxxxx during Labor management is MEDICAL and for a MEDICAL condition treatment.

For consideration, please include the following medical documentation:

- **Office Notes**
- **Operative Notes**
- **Treatment notes, including outcomes**
- **Lab Results**
- **Documentation to support the procedure (s) billed**
- **Consultation requests and/or reports**

Submit any medical records that support the medical necessity of services being denied.

According to both Medicare and the American Academy of Obstetrics, is indicated for the first-time treatment of mild to moderate signs and symptoms of the patient. The patient has a history of several underlining conditions: indication of xxxx, and mode of arrival/admit reason diagnosis of xxxx.

In support of this claim, please find enclosed a copy of the specified type of results (lab, treatments include for review, etc.) confirming the diagnosis xxxx and letter of the medical necessity of history and physical findings for xxxx diagnosis of treatment possibly an indication of the condition of care standards reports from the patient's physician.

Additionally, clinical findings as listed in clinical notes are enclosed for review.

Thank you for your prompt attention to this matter.

Sincerely,

Jane Doe

V. Conclusion

Now that you have included all the basics for a successful appeal letter, you want to perform a final check and review some items that you may need to include. To authenticate your appeal letter, try to include a letter from your Physician. It helps to validate the findings of your appeal letter. Also, consider sending a copy of your appeal letter to the Healthcare Plan Medical Director, Primary Care Physician, and/or treating physician.

If you have any additional questions, or you would like to schedule a consultation to speak with Gateway Healthcare Solutions, please feel free to send an email to info@gatewayhealthcaresolutions.com. We deliver quality beyond expectations.