NeKY RHIO
Northeast Kentucky Regional Health Information Organization

Appeal Checklist & Tips

Below is a checklist of the forms and documents you may need for an appeals package if an insurer denies treatment to your patient.

Please Note: Each insurer and each patient might need different information. Please review each denial and the insurer's guidelines, to determine what to include in your patient's appeals package.

- Statement of Medical Necessity
- Patient Authorization and Notice of Release of Information
- Copy of the patient's health plan or prescription card (front and back)
- Appeal letter
- Denial information including the patient's denial letter or Explanation of Benefits letter
- Supporting documentation:
    - Patient history and physical finding
    - Health care provider's chart notes
    - List of current medication, with dose and frequency
    - List of treatments tried without success
    - Test and lab results
    - Hospital admission/emergency department notes
- Other supporting documents, including journal articles, abstracts, textbook excerpts, practice guidelines and/or compendia indications

Appeal Tips

Some helpful tips for handling common issues in denials

Denial Reason

Find out in writing why the authorization request has been denied. The reason should be on the letter of denial sent from the patient's health plan or on the Explanation of Benefits (EOB) letter. If you did not receive one, it can be obtained from the insurer. If you buy and bill for this patient, include the letter of denial with the corrected claim form in your appeal. Do not resubmit a claim unless you understand this.

Appeal Guidelines

Contact the insurer to find out its appeal deadline, the number of appeals allowed and the mailing address or fax number for the appeal. Submit your patient's appeals package before the deadline. Some insurers have short appeal periods. An immediate response could be crucial. Some plans allow only one appeal. Also, as if the patient or the health care providers submits the appeal.

Phone Contact

Many denial letters include a telephone number for the review department for physicians to call. If the reviewer sees the merits of your argument and then approves treatment for the patient during the call, the appeals process is completed.

Written Appeal

Most insurers require a written appeal from either the member or the health care provider. The insurer should tell you what it needs. A written appeals package has an appeal letter and supporting documents.

Other supporting Documentation

Your patient's appeals package should include any medical documentation supporting your case for coverage. This can include your health care provider notes and appropriate test results to support this choice of treatment.

Patient's Insurer

Do you know the type of insurance your patients has? Is the treatment or service a covered benefit? Do state laws apply? Have your patient check the benefit plan or booklet to determine whether the requested treatment is excluded. If it is, be prepared to give written support why the plan should make an exception for your patient. You could also pursue an independent external review, depending on the state where your practice located.

Certified Mail

Genentech Access Solutions strongly suggests you send the appeals package via certified mail.

Follow-up

If the patient's insurer has not responded within 30 to 60 days of receipt of the appeals package, contact the insurer to find out the status.

Complete Records

Keep a copy of everything you send with the patient's appeal. Keep a log of every phone call you make to the patient's insurer. Write down the date and the name of the person with whom you spoke.