When you receive medical care, either you or your provider (doctor, hospital, therapist, etc.) must file a claim with your health insurer. Often, the provider files the claim.

Most of the time, the insurer pays the claim. But, sometimes the insurer refuses to pay part or all of the claim for services you believe should have been covered. You have a right to appeal that decision.

There are two types of appeals—an and an

You file an internal appeal to ask your insurer to review a decision to deny a claim. You have up to six months (180 days) after you learn a claim was denied to file an internal appeal.

- To learn how to file an internal appeal, look at the claim denial or call the customer service number on your insurance card/materials.
- An internal appeal usually requires you to write a letter. Be sure to include in the letter your name, claim number, and health insurance ID number, and any other information you have to support your claim. (See reverse side for sample letter.)
- If the insurer denied a claim for a medical reason, you'll need your health care provider's help to file an appeal. Ask your provider to write a letter explaining why the care was medically necessary. Send that letter with your appeal.

After it receives your appeal, the insurer has a set amount of time to review it and make a decision. How much time the insurer has varies by state. If a delay in receiving medical care could harm your life, health, or ability to function, you can ask that the appeal be reviewed quickly ("on an expedited basis").

If your insurer still denies the claim after the internal appeal, you can ask for an external review. An independent review organization will do the external review. You may have a limited time to ask for an external review after you receive the decision from your internal appeal.

- You should find the information about how to ask for an external review on your internal appeal notice.
- Your state's insurance regulatory agency is usually in charge of the external review process.
- You can submit information you didn't include in your internal appeal

conversations, and details of all conversations. Ask about and make notes of any set deadlines for expected responses or information from your insurer.