Appealing Your Insurer's Decision Not To Pay

If your health insurance company does not cover your specific health care provider or service, you have the right to ask for an appeal. For prescription drugs, an "exceptions" process is also available. To learn more about the exceptions process, read "Know Your Rights." Directions are listed on the information your insurance company sent you when they denied your claim.

In general, there are two types of appeals:

- 1. An internal appeal (an appeal directly to your insurance company)
- 2. An external appeal (an appeal decided by an independent third party)

Internal appeal

If you decide to ask for an internal appeal, you must file the internal appeal within 180 days (about 6 months) of getting notice that your claim was denied. You can also file an appeal that would get you a quicker decision if the timeline for the standard appeal process would seriously put your life at risk, or risk your ability to fully function. 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, such as a letter from the doctor.

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

External appeal

If you decide to ask for an external review, you must file a written request. The notice your health insurance company sends you should tell you the 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 written final denial of the internal appeal will include the contact information for the independent third party that will handle your external review.
- The external reviewer will issue a final decision. An external review either keeps your insurance company's decision, or decides in your favor. Your insurance company is required by law to accept the external reviewer's decision.
- Standard external reviews are decided as soon as possible. If you meet the standards

for this expedited external review, the final decision about your appeal must come as quickly as your medical condition requires, no later than 72 hours after your request for external review is received.

Getting help with your appeal

- There are many resources available to help you with your appeal. You don't have to do it alone.
- You can call the Marketplace Call Center at 1-800-318-2596, 24 hours a day, 7 days a week. TTY users should call 1-855-889-4325.
- You also can visit HealthCare.gov to get more information about appeals.
- Your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help you, along with other local organizations. Visit LocalHelp.HealthCare.gov to find help in your area.
- Your insurance company's consumer hotline will provide you with information. A list of such hotlines is available on HealthCare.gov.
- If you don't speak English, you can get help and information about appeals and other Marketplace issues in your preferred language at no cost. To talk to an interpreter, call 1-800-318-2596. TTY users should call 1-855-889-4325.
- You can 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.

