

Step 2: Gather Preliminary Information

If you do not already have a file and a notebook to document all correspondence, start one now. You should keep a record of all letters you receive and a log of all telephone calls you make or receive related to the denial. Over time you may forget people's names and dates. This documentation will help you stay organized and focused on your goal. There are specific questions you need to ask once you are notified the procedure will not be covered through pre-authorization.

- When did you receive notice of the denial?
- How did you receive notification of the denial?
- Did your doctor notify you directly, or did the administrator or insurer notify you directly?
- Did you receive a letter or phone call from the insurance company?
- Did you receive a statement from your insurance company stating that your bills will not be paid?

First and foremost, **you need to get a copy of the denial letter**. Under the Employee Retirement and Income Security Act (ERISA), your denial letter should include a **specific reason** for the denial and a reference to your plan explaining the basis for the denial. For example, is your insurance company denying to pay for your treatment because it considers it to be experimental? Or, do you belong to an HMO that does not have out-of-network benefits and you wish to go to an out-of-network provider? Place a call to the doctor's office and find out what information was submitted to the insurance company and ask for a copy of the information and the letter written by your doctor requesting payment authorization.

If your requests are ignored, you should put them in writing to make a record of your attempts to obtain the information you need. If you have received a denial for a procedure that has already taken place and there are bills that are unpaid, you need to begin to backtrack to find out why.

- Does your insurance company require procedures to be pre-authorized?
- If so, did your doctor's office pre-authorize the procedure?

This brings up the most important documents you have and need: your **plan document** and **plan summary**, or **health insurance booklets**. The plan document and plan summary are essentially a contract between you and the insurance company. You need to be sure that you have a current copy. If you do not have a copy, you must write to the plan administrator and request that a copy be sent to you. Under ERISA, these documents must be sent to you within thirty days of the written request or the company may be assessed penalties. **READ** your plan language. What does it say about your procedure and specific reason for denial? Under ERISA, a specific reason for denial must be stated in language that would be understandable to an employee. If the procedure was to be pre-authorized, do you or your doctor have a copy of the authorization or the approval from the insurance company? If no pre-authorization was required review specific exclusions listed in your plan. If your treatment is not identified as a specific exclusion, you need to begin your appeal.

- Who can you contact to discuss the denial?

You need specific names and numbers of contact people. The denial letter from the insurance company may contain this information. You may need to call the insurance company and ask for a contact person. Be sure to ask for that person's direct line. Ask the staff at your doctor's office who you can call to ask questions and get any letters or records you may need. If you will be receiving your treatment at a facility away from home, be sure to have the name and number of your treating doctor's nurse. You will likely need to get letters from the treating doctor as well. You also need to be sure that you have a written copy of the steps that you must take in order to appeal the denial. This information should be in your plan document. It may also be in the denial letter. You may need to

request this information from the insurance company. Be sure you understand each step of the appeal process. It is your path to obtaining reimbursement.

By answering these questions and collecting these documents you have the initial information you need. You have your plan document, your denial letter and you have the names of the contact people at the insurance company and the doctor's office. Now you must begin to educate yourself and continue to research the issue to achieve your goal of reimbursement. If you still do not understand your rights, or the appeal process is unclear, and the employer or insurer will not or cannot explain further, it may be helpful to contact an attorney.