NORD National Organization for Rare Disorders | CLAIM YOUR Care | Increasing Knowledge of Rare Disease Health Care Coverage

Medicare: Denials and Appeals

Receiving a letter from your insurance company denying a specific medication or service can be stressful and frightening. It is important that individuals are aware of their options.

Denials and appeals processes ensure that individuals have the right to dispute denied claims.

The health plan documents you receive after enrollment or included within denial letter(s) you receive will outline your rights to appeal and instructions about how to proceed.

Read Your Denial Letter Carefully!

How do I file an appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. For example, you can appeal if Medicare or your plan deny:

- A request for a health care service, supply, item, or drug you think Medicare should cover.
- A request for payment of a health care service, supply, item, or drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or drug.

If you have Original Medicare:

Start by looking at your **"Medicare Summary Notice"** (MSN). You must file your appeal by the date on MSN. If you missed the deadline for appealing, you may still file an appeal and get a decision if you can show good cause for missing the deadline (for example, if you had an illness or accident that delayed you from sending it by the deadline).

- Fill out a Medicare Redetermination form and send it to the company that handles claims for Medicare. Their address is listed in the "Appeals Information" section of the MSN.
- Or send a written request to the company that handles claims for Medicare to the address on the MSN.
- Include this information in your written request:
  - Your name, address, and the Medicare number on your Medicare card.
  - Circle the items and/or services you disagree with on the MSN. Or list the specific items and/or services or which you are requesting redetermination, and the dates of service.
  - An explanation of why you think the items and/or services should be covered.
  - The name of your representative if you have appointed a representative.
  - Any other information that may help your case.

You will generally get a decision from the Medicare Administrative Contractor within 60 days after they get your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.

If you have a Medicare health plan:

Start the appeal process through your plan. Follow the directions in the plan's initial denial notice and plan materials.

- You, your representative, or your doctor must ask for an appeal from your plan within 60 days from the date of the coverage determination. If you miss the deadline, you must provide a reason for filing late.
- Include this information in your written request:
  - Your name, address, and the Medicare number on your Medicare card.
  - The items or services for which you are requesting reconsideration, the dates of service, and the reason(s) why you're appealing.
  - The name of your representative and proof of representation if you have appointed a representative.
  - Any other information that may help your case.
- If you think your health could be seriously harmed by waiting the standard 14 days for a decision, ask your plan for a fast or "expedited" decision. The plan must give you its decision within 72 hours if it determines, or your doctor tells your plan, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

How quickly your plan must respond to your request depends on the type of request:

- Expedited (fast) request— seventy- two (72) hours.
- Standard service requests thirty (30) calendar days.
- Payment request— sixty (60) calendar days.

If you have a separate **Medicare drug plan** and get a medication denial:

Start the appeal process through your plan.

If you are asking to get reimbursed for drugs you already purchased, you or your prescriber must make the standard request in writing. Write your plan a letter, or send them a completed **"**Model Coverage Determination Request**"** form.

If you are asking for a prescription you haven't gotten yet, you or your prescriber can ask your plan for a coverage determination or an exception. To ask for a coverage determination or exception, you can do one of these:

- Send a completed **"**Model Coverage Determination Request**"** form.
- Write your plan a letter.
- Call your plan.
- If you are asking for an exception, your prescriber must provide a statement explaining the medical reasonwhy the exception should be approved.

- If you did not get the prescription yet, you or your prescriber can ask for an expedited (fast) request. Your request will be expedited if your plan determines, or your prescriber tells your plan, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

How quickly your plan must respond to your request depends on the type of request:

- Expedited (fast) request— twenty-four (24) hours.
- Standard service request— seventy-two (72) hours.
- Payment request— fourteen (14) calendar days.

Maintain documentation:

- Keep copies of all correspondence and notes related to your denials and appeals. This includes notices from your health plan, medical records, and any written or verbal communications. Make notes when you call your health plan. Include dates, times, names of representatives with whom you have spoken, what was discussed, and the case number (if assigned).

Resources

Medicare online: https://www.medicare.gov/

Your state health insurance assistance program: https://www.shiphelp.org/

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