How to Deal with an Insurance Denial

Shared decision-making and a trusted physician-patient relationship are cornerstones of patient-centered care. Sometimes, however, health insurers can disrupt care by delaying or denying access to physician-prescribed medications.

Patients can appeal their insurance company's denial. They also have options when those appeals don't resolve the problem.

Every state oversees health plans and can act as a liaison between insurance companies and the people they serve. If you have been denied access to treatment, you can file a complaint.

Try to resolve the issue directly.

First try to solve the problem by following your insurance company's appeals process. You must file your appeal within **six months** of receiving notice that your claim was denied. At the end of the internal appeals process, your insurance company must provide you a written decision.

Request an external review.

If the insurance company's final decision is unsatisfactory, you have the right to take your appeal to an independent third party for review. This is called external review.

See this state list maintained by the Department of Health and Human Services' Center for Consumer Information & Insurance Oversight to learn more about your state's external review.

File a complaint with your state insurance department.

There are a variety of reasons you might file a complaint, such as:

- Your insurer or pharmacy benefit manager requires you to first try and fail a medication that was ineffective for you with a previous health plan
- Your health plan refuses prior authorization or re-authorization requests for a prescribed medication that is FDA-approved for your condition

- You're denied a medically necessary drug because it is not listed on your insurer's coverage formulary.

State-specific links for filing a complaint are available at allianceforpatientacccess.org

Be prepared to provide the following information:

- The reason for your complaint
- Your name and contact details
- The name of your insurance company, type of insurance, policy number and the state where the plan was purchased
- Information about your insurance claim, including claim numbers and dates
- Any documents with additional information you sent to the insurance company (like a letter from your doctor)
- A description of what you consider to be a fair resolution.

Most states are required to follow up in a defined period, usually 30-45 days.

Consider additional steps.

If filing a complaint does not resolve the problem, you can seek arbitration, if that is an option in your insurance policy. You may also consider filing a legal claim against your insurer in court.

Don't give up.

A little perseverance can go a long way toward ensuring patient-centered care.

AfPA | Alliance for Patient Access

The Alliance for Patient Access advocates at the federal, state, and health plan levels for key health reforms that increase access and personalized care for all patients.

AllianceforPatientAccess.org