How to Appeal a Denial

Child Neurology FOUNDATION

If your procedure, test, or healthcare provider visit is denied, follow these steps to determine if a denial is warranted. If the service is covered by your plan and is denied, you have the right to appeal.

1 Review Explanation of Benefits

- This is not a bill. It's a **summary of your health insurance claim**, explaining what was denied, why it was denied and how to appeal.
- Understand **what** service that was denied.
- Understand **why** it was denied. Read the denial reasons carefully - there may be more than one.
- Understand if the denial was for a **prior authorization** (before the service was performed) or an **insurance claim** (after the service was performed).

2 Review Appeal Instructions

- The instructions on how to submit an appeal will be included on your Explanation of Benefits.
- Review the instructions on **how to submit** for an appeal (fax, email or mail).
- **Keep a copy** for your records.
- **Use certified mail** and keep the tracking number.

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3 Prepare Appeal Submission

- **Contact your healthcare provider**, let them know you are appealing the denial, and ask for assistance.
- Request **clinic notes** and a **letter of support** from your doctor or healthcare provider explaining the need and the benefit
- Make sure to **include**:
  - ☐ Why the service was ordered
  - ☐ How it will impact the patient's health
  - ☐ Your statement addressing each denial reason
  - ☐ Background information on your disease (resources from CNF or NORD)
  - ☐ Clinical guidelines or evidence supporting the test (provided by your doctor)
  - ☐ Cover letter summarizing the appeal
  - ☐ Denial letter or EOB

4 Submit & Confirm Receipt

- Contact your insurance to confirm they received your appeal. They must respond within 30 days for prior authorizations and 60 days for claim denials.

5 Denied Again?

- Consider requesting an **External Review**.
- **Federal law** allows you to request an independent review if your appeal is denied. Your insurance must provide instructions on how to request this.

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External Review Steps

- You must file a **written request** within 4 months of the final denial.
- Include any **new information** since your last appeal and
- Request a **review by a specialist** in the same field (e.g., neurologist).

Reasons a Prior Authorization or Claim May Be Denied

Clerical Error or Missing Information: Ask the provider to correct and resubmit. You do not need to appeal if this is the only denial reason.

Out-of-Network: Request an exception or find an in-network option.

Non-Covered Service: Appeals often won't succeed for tests excluded by your health plan.

Timely Filing: If the deadline was missed, an appeal is unlikely to succeed.

Not Medically Necessary (NMN): Review the criteria for coverage and ensure all necessary documentation is submitted.

Experimental or Investigational (E/I): These are less likely to be successful as your insurance determined the service lacks supporting evidence but including evidence like published studies and clinical guidelines may help.

If you have specific questions about navigating your insurance, contact the CNF Family Support Program at childneurologyfoundation.org/family-support or call (859) 551-4977.

Family Support