Tennessee Medical Association

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ERISA Appeals Letter
Notice of Denied Claim

[Date]

[Employer Plan Administrator]
[Address]

RE: [Patient Name
Patient Address
Patient Phone Number
Patient DOB
Patient SSN/Health Plan ID
Group Policy Numbers]

To whom it may concern:

This letter is to notify you that I am acting as the authorized representative for the above indicated patient and am submitting this appeal for the reason(s) indicated below. Enclosed please find a copy of the patient signed Assignment of Benefits Form, authorizing me to act as the patient's representative in this appeal.

In accordance with [Plan Administrator's] appeals procedures, I am sending this letter to appeal the denial of a claim sent xx/xx/xxxx for services provided to the above indicated patient on xx/xx/xxxx. Federal regulations give me at least 180 days from receipt of the determination of benefits to appeal. 29 CFR §2560.530-1(h)(3)(i). Enclosed please find the original claim and supporting documentation.

Notice of Denied Claim (Adverse Benefit Determination)
Pursuant to federal law, you are required to:

1. Provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
2. Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. 29 USC §1133.

When a claim is denied, federal regulation requires HEALTH PLAN to provide determination of benefits within [15 days of receipt of a pre-service claim or 30 days of receipt of a post-service claim]. 29 CFR §2560.503-1(f)(2)

The determination of benefits must include:

- Specific reasons for denial,
    - Courts have held that a mere conclusory statement that service was not "medically necessary" (*Weiner v. Health Net of Connecticut*, 311 Fed.Appx. 438, 441 (2d Cir. 2009)) or that "the claims were processed incorrectly" (*Harlick v. BlueCross BlueShield of California*, 686 F.3d 699 (9th Cir. 2012); *Flinders v. Workforce…*, 491 F.3d 1180, 1191 (10th Cir. 2007) are insufficient reasons to deny a claim.
- Reference to specific plan provisions on which determination was based,
- A description of any additional material or information necessary for me to perfect the claim,
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of my right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination,
- Copy of internal rule or guideline of use in making denial or a statement that I may access them free of charge, and
- Statement that explanation of scientific or clinical judgment used in making denial will be provided free of charge if denial was based on medical necessity. 29 CFR 2560.503-1(g).

The determination of benefit notice our office received from [Plan Administrator] was insufficient for the following reasons:

- ☐ Notice was sent beyond the time limit required by federal regulation
    - Claim was sent on xx/xx/xxxx, adverse benefit determination (denial) received on xx/xx/xxxx.
- ☐ Notice did not include information required by federal regulation, including:
    - ☐ Specific reasons for denied claim
    - ☐ Quoted specific plan provisions
    - ☐ Statement regarding access to all information relied upon for denial
    - ☐ Description of appeals process
    - ☐ Internal rules or guidelines
    - ☐ Statement regarding scientific or clinical judgment used in making denial

<u>Notification of Benefit Determination upon Review</u>

For the reasons stated above and found within our supporting documentation (enclosed), we seek appeal of the above referenced denied claim. Upon receipt of this appeal letter, you have [60 days if plan requires one level of appeal or 30 days if plan requires two levels of appeal] to review the appeal and send notification of [Plan Administrator's] benefit determination on appeal to the address indicated below. 29 CFR §2560.503-1(i)(2)

Please note that federal law prohibits [Plan Administrator] from taking any retaliatory actions against me, my practice, or the above indicated patient. 29 USC §1140. If any such action is

taken, the injured party reserves the right to file a complaint with the US Department of Labor and may be entitled to injunctive relief.

As authorized representative for the above indicated patient, I request full reimbursement of the previously denied claim described above. Please see attached documentation for further explanation.

Sincerely,

[Treating Physician]