

Model Notice of Final Internal Adverse Benefit Determination

Date of Notice
Name of Plan
Address

Telephone/Fax
Website/Email Address

This document contains important information that you should retain for your records.

This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

Name:	ID Number:
Claim #:	Date of Service:
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	Allowed Amt.	Other Insurance	Deductible	Co-pay	Coinsurance	Other Amts. Not Covered	Amt. Paid
YTD Credit toward Deductible:			YTD Credit toward Out-of-Pocket Maximum:				
Diagnosis:							
Diagnostic Codes:			Requested Service(s)/ Treatment Code:				
Treatment Category (Subcategory):			Denial Codes:				

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: *Describe facts of the case including type of appeal and date appeal filed.*

Final Internal Adverse Benefit Determination: *State that adverse benefit determination has been upheld. List all documents and statements that were reviewed to make this final internal adverse benefit determination.*

Findings: *Discuss the reason or reasons for the final internal adverse benefit determination.*

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Important Information about Your Rights to External Review

What if I need help understanding this denial? Contact us [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? For most types of claims, you are entitled to request an independent, external review of our decision. Contact us [insert contact information] with any questions on your rights to external review.

How do I file a request for external review? [Insert instructions in place of detachable form at the bottom of this page. If there are no current procedures applicable, insert: Detach and send in the bottom of this form within [insert timeframe].]

What if my situation is urgent? If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by [insert instructions to begin the process (such as by phone, fax, electronic submission, etc.)].

Who may file a request for external review? You or someone you name to act for you (your authorized representative) may file a request for external review. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, once your external review is initiated, you will receive instructions on how to supply additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at [insert contact information].

What happens next? If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].]

Appeal Filing Form

[Insert Insurer Name]

[Insert Phone Number/ Mailing Address]

[Insert Name and ID Number]

[Insert Claim #]

Detach this form and send to: [Insert name and contact information]

NAME OF PERSON FILING APPEAL: _____

Covered person Patient Authorized Representative