Where to Start if Insurance Has Denied Your Service and Will Not Pay

If your insurance plan refuses to approve or pay for a medical claim, according to the terms or procedures ordered by your doctor, you have guaranteed rights to appeal. These rights were expanded as a result of the Affordable Care Act for certified plans. Review your denial letter carefully as it outlines your next steps for appealing the decision.

Your insurance must provide:

- Information on your right to file an appeal
- The specific reason your claim or coverage was denied
- Detailed instructions on submission appeals
- Key timelines to submit your appeal
- The availability of a Consumer Assistance program in some states

Remain your insurance or may deny your payment or not approve. Reasons your insurance may be:

- Services deemed not medically necessary
- Services are no longer appropriate in a specific healthcare setting or level of care
- The effectiveness of the medical treatment has not been proven
- You are not eligible for the benefits covered under your health plan
- Services are considered experimental or investigational for your condition
- The claim was not filed in a timely manner

Your health plan cannot drop your health plan or part of the health plan's decision.

Health insurance companies are all required to give you in an annual review process that outlines insurance company's decision from the drug manufacturer to help you. Charity assistance or financial help to pay the full cost. If your exemption request is not approved, you will be responsible for the full cost.

Medication-related Barriers

Navigating the Plan’s Medication List and Drug Formulary

M edications can be a large part of the financial burden for patients, especially if dealing with a chronic or life-threatening condition. To protect yourself, when prescribed a medication, compare the medication to your insurance plan’s drug list to see if the medication is on the approved list. To avoid the costs not to be paid in order to receive the prescription. If your prescription is not covered on the plan formulary, consider switching to the generic version of the drug or paying:

- Formally request an exception to the formulary list. Your request will be processed in conjunction with the prescribing provider and should include documentation supporting the medically necessary reason for a non-formulary medication to cover your condition.

If your appeals request is not approved, you will be responsible to pay the full cost.

Seek out copayment programs, charity assistance or financial help from the drug manufacturer to help pay for medications.

Find tips for talking about medication costs and the appeal process inside.


**Dropped Coverage**

Issue with premium payment

- If you make a premium payment, your insurer has the right to deny coverage or cancel your policy.

- Consider setting up an automatic premium payment plan ensuring timely payment and amount of premium paid.

- If you are enrolled in a Marketplace plan and cannot afford the premium, the contact the Marketplace to see if you qualify for additional support. If so, continue on your policy but make sure to have your premiums paid, whether for health or non-profit programs that may offer financial help with premiums.

- Paying an overbalance will not necessarily reinstate your policy.

**Addressing Financial Challenges**

- Individual and family of one or two people:
  - If you have a bill you cannot pay, ask the provider or medical financial counselor from the provider’s office to look for any programs that provide information about eligibility for affordable payment plans, prepayment discounts, or other financial assistance given by the provider.

- For talk about costs
  - Initialize this conversation without assuming your provider will volunteer the information.
  - Be sure to inventory your options for all possible medical services billed, as many have separate groups in place for each type of service.
  - Be polite and respectful, but also persistent. Call back or follow up as needed.

**Preparing for Costs**

- This will also ensure you are informed decision on participating.

- Non-covered services, to make an informed decision.

- For example, include follow-up doctor diagnosis undergoing treatment.

- Plan for patients with the same life-threatening conditions.

- Routine costs are defined as treatment of cancer or other serious conditions.

- Of routine patient costs for items longer deny or limit the coverage

- Insurance companies can no longer deny or limit the coverage

- Examples include follow-up doctor diagnosis undergoing treatment.

- Marketing your treatment protocol. This may necessarily reinstate your policy.

- Accessing “Experimental” or “New Care” can provide additional treatment options outside of the standard of care.

When you enroll in a clinical trial, there is no guarantee the services or medications directly related to the trial, or that are not considered routine care for your treatment plan.

- Sometimes your medical claim is denied in the process of this review.

- In delays in medical services due to routine care, specialty care, emergency care, or home health. In this scenario you need to review the policy language or your provider to determine how much you can expect your insurer to pay.

- Financials should have an annual budget or set aside amount that allows you to afford expenses up the annual deductible and non-covered services associated with your plan. Does this give you the possible ability avoid your annual deductible? It is important that you are informed about your financial responsibility.

- You will want to ask for a detailed plan for patients with the same life-threatening conditions.

- As a plan member, you have the right to review the policy language or your provider to determine how much you can expect your insurer to pay.

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