Date of Notice:
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records.
This document serves as notice of an 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 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.]

Explanation of Basis for Determination:
If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at [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? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Detach and send in the bottom of this form within [insert timeframe, for example, X days from the date of this notice]. [If electronic notice, insert alternate submission instructions.]

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. 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 your appeal. If you believe your situation is urgent, you may request an expedited appeal by [insert instructions for filing internal appeals (and, if applicable, simultaneous external review)].

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

Can I provide additional information about my claim? Yes, you may supply additional information. [Insert any applicable procedures for submission of 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 appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your appeal 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 Name and ID Number] [Insert Claim #]
[Insert Patient Name]

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

NAME OF PERSON FILING APPEAL: _____

□Covered person □ Patient □ Authorized Representative