SAMPLE LETTERS

The sample letters which follow refer to various sections of law. Be certain that your letter refers, not necessarily to the section identified in the letter, but to the pertinent section of law.

Please Note: The following sample letters have been recently updated or added to this Manual. (12/09).

Each letter written should be individually tailored to the particular situation. These sample letters should not be reproduced, but portions may assist you in composing your own letters.

This sample letter may be used when no specific reason was provided for denial of claims.

[Letterhead]

[Date]

Claims Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Claims Department]:

I am in receipt of [Insurance Company's] letter of claim denial dated [date of receipt of denial letter]. I am writing in regards to the denial for the following date(s) of service:

1. [Date #1]
2. [Date #2]

The claim was submitted timely on [date claim was submitted]. Upon review of the denial letter, [Insurance Company] failed to provide the reasoning for denying the claim.

According to California Health & Safety Code Section 1399.55 and California Insurance Code Section 10123.13, insurers and plans must disclose the specific reasons, including for each reason, the factual and legal basis known at that time by the insurer denying the claim. Thus, I respectfully request that I be provided the specific reason for the denial of the aforementioned claim within ten (10) business days of receipt of this request.

Please contact me at [daytime telephone number] for any additional information you find necessary to complete my request. Your prompt attention to this matter is greatly appreciated. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when the claim was denied due to a lack of medical necessity.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter of claim denial dated [date of receipt of denial letter]. I am writing to appeal the denial for the following date(s) of service: [dates of service]. The claim was timely submitted on [date claim(s) were submitted]. The denial letter states that the claim was denied based on a lack of medical necessity.

[Provide a brief discussion about the background of patient, including diagnosis and treatments. If available, insert the definition of "medical necessity" from the insurer's policy manual. Discuss the reason why treatment services provided were deemed medically necessary and the likely results of not providing said services.]

Thus, I request this matter be promptly reviewed and reimbursed in the total amount of [insert amount of monies owed plus interest]. If [Insurance Company] does not agree with the above stated reasons why the treatment services were deemed medically necessary, I respectfully request that I am provided with specific reasons why [Insurance Company] considers the services not medically necessary.

Please contact me at [daytime telephone number] for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when the claim is denied because the provider is a licensed marriage and family therapist.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter of claim denial dated [insert date of receipt of denial letter]. I am writing to appeal the denial for the following date(s) of service: [Insert dates of service]. The claim was timely submitted on [insert date claim(s) were submitted].

In its denial letter, [Insurance Company] provided the reason the claim was denied was due to patient's selection of a California Licensed Marriage and Family Therapist to render mental health services.

According to California's "Freedom of Choice" laws (California Insurance Code Sections 10176, 10176.7, 10177, and 10177.8 and California Health & Safety Code Section 1373), patients have the right to select the licensed mental health provider of their choice. Licensed marriage and family therapists are specifically named in the "Freedom of Choice" laws. I am a licensed marriage and family therapist in California. My license number is [license number].

Thus, I respectfully request that this matter be promptly reviewed and the aforementioned claim be reimbursed in the amount of [amount of monies owed plus interest], which includes reimbursement plus required interest. Please contact me at [daytime telephone number] for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when the claim was denied due to modification or retraction of an authorization for treatment.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter of claim denial dated [insert date of receipt of denial letter]. I am writing to appeal the denial for the following date(s) of service: [Insert dates of service]. The claim was timely submitted on [insert date claim(s) were submitted]. In its denial letter, [Insurance Company] provided the reason for denial indicating that prior authorization received for the services performed was [not provided, incorrect, not covered].

On [date], I called [Insurance Company] and spoke to [agent name] to verify patient health benefits eligibility, as well as to obtain authorization for treatment. [Agent name] informed me that [patient name] was indeed enrolled; determined services were medically necessary and provided authorization for treatment. Based upon [Insurance Company's] authorization, I provided treatment to patient on [insert dates of service].

[Provide a brief discussion of the background of the patient, including diagnosis and treatment. Discuss why treatment services provided were deemed medically necessary.]

According to California law, a plan may not modify or retract authorization after the provider renders the service in good faith and pursuant to the insurer's authorization. California Health & Safety Code Section 1371.8 provides that, "a health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility."

Furthermore, such authorization constitutes an implied promise to reimburse me for rendering professional services. Due to the authorization provided to me by [Insurance Company], I

reasonably expected to be reimbursed for rendering services to [patient name]. As a sole practitioner, my livelihood depends upon prompt reimbursement for rendering professional services. If [Insurance Company] had not authorized such treatment, the patient and I would have arranged some other financial arrangement or I would have referred and not provided services to said patient. An error made on the part of [Insurance Company] or its employee is not a valid reason to deny reimbursement. As a provider, I have no way of accessing [Insurance Company's] internal administrative information to determine authorizations for treatment services.

Consequently, I, in good faith, reasonably relied on information given to me by [Insurance Company's] agents and employees. California law and equitable principles of fairness mandate that I be reimbursed accordingly for the treatment services I provided based on this good faith reliance. It is unlawful for [Insurance Company] to attempt to retract an authorization once it has been given and acted upon by the provider.

Thus, I respectfully request that this matter be promptly reviewed and reimbursed me in the amount in the amount of [amount], including interest. Please contact me at [daytime phone number] for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when the claim was denied because the insurance company is located out of state, but the client is employed and resides within the state for a policy written after January 1, 1985.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter of claim denial dated [insert date of receipt of denial letter]. I am writing to appeal the denial for the following date(s) of service: [Insert dates of service]. The claim was timely submitted on [insert date claim(s) were submitted]. In its denial letter, [Insurance Company] stated that it denied the claim because the services were performed by a licensed marriage and family therapist.

California law mandates that an insurer pay for services rendered by a licensed marriage and family therapist even when the policy is written or issued for delivery outside of California, provided that the policy was issued for delivery in California.

California Insurance Code Section 10176.7 provides that individuals who are covered under an insurance plan where the insurer is licensed to do business in California and provides coverage under a contract of insurance, which includes California residents, may choose a licensed marriage and family therapist to provide services that are within the scope of practice for marriage and family therapists. Although the insurance contract was written outside of California, the fact that the coverage includes California residents, [Insurance Company] must abide by California laws. [Insurance Company] provides coverage under an insurance contract that consists of California residents, including [patient name]. According to California's "Freedom of Choice" laws (California Insurance Code Sections 10176, 10176.7, 10177, and 10177.8 and California Health & Safety Code Section 1373), patients have the right to select the mental health provider of their choice. Licensed marriage and family therapists are specifically mentioned in the "Freedom of Choice" laws.

I am licensed as a marriage and family therapist in California. My license number is [license number]. The services provided to [patient name] were within the scope of practice of a licensed marriage and family therapist. Licensed marriage and family therapists in California practice

psychotherapy and may diagnose and treat mental disorders. [Patient] was being treated for [discuss treatment services].

Thus, I respectfully request that this matter be promptly reviewed and [Insurance Company] reimburse me [insert amount of monies owed plus interest]. Please contact me for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when the insurer requests a reimbursement for the overpayment of a claim.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter requesting reimbursement for the overpayment of the above mentioned claim. The claim was timely submitted on [date claim was submitted]. I am writing to appeal the refund request on the basis of California law, equitable principles of fairness and justice, and respectfully request that [Insurance Company] cease its collection efforts on said claim.

On [date], I called [Insurance Company] and spoke to [agent name] to verify patient health benefits eligibility, as well as to obtain authorization for treatment. [Agent name] informed me that [patient name] was indeed enrolled and provided me authorization for treatment. Based upon [Insurance Company's] authorization, I provided treatment to patient on [insert dates of service].

[Provide a brief discussion of the background of patient, including diagnosis and treatments. Discuss the reason why treatment services provided were deemed medically necessary.]

On [date payment received], I received an Explanation of Benefits and a check in the amount of [total amount of monies paid for services] for the services I rendered to patient. Pursuant to the Explanation of Benefits, patient reimbursed me [total amount of copayment monies received from patient] for [his/her] share of the total balance. Since [Insurance Company] authorized and reimbursed for the treatment services I provided to [patient name], I reasonably expected to be compensated at the reimbursed rate for continuing to render such services to the patient.

An error made on the part of [Insurance Company] or its employee is not a valid reason to demand a refund for overpayment. As a provider, I have no way of accessing [Insurance Company's] internal administrative information to determine authorizations and reimbursement rates for treatment services. Rather, I rely on information given to me by [Insurance Company] agents and employees.

According to California law, a plan may not modify or retract authorization after the provider renders the service in good faith and pursuant to the insurer's authorization. California Health & Safety Code Section 1371.8 provides that, "a health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility."

Consequently, I, in good faith, reasonably relied on the information given to me by [name of agent], who is an employee of [Insurance Company], as well as the Explanation of Benefits and reimbursement check sent to me from [Insurance Company]. Injustice can only be avoided by ceasing to collect the monies paid to me for the treatment services I provided based on this good faith reliance.

Thus, I am requesting [Insurance Company] cease any and all collection efforts on the aforementioned claim. Please contact me for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when the insurer will not reimburse until the amount the insurer claims owed is recouped.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter indicating its decision to not reimburse the claim that was timely submitted on [date claim was submitted] until it has recouped an alleged overpayment of a previous submitted claim. I am writing to appeal this decision and respectfully request that [Insurance Company] reimburse me for the said claim.

On [date], I called [Insurance Company] and spoke to [agent name] to verify patient health benefits eligibility, as well as to obtain authorization for treatment. [Agent name] informed me that [patient name] was indeed enrolled and provided me authorization for treatment. Based upon [Insurance Company's] authorization, I provided treatment to patient on [insert dates of service for previous submitted claim].

[Provide a brief discussion of the background of patient, including diagnosis and treatments. Discuss the reason why treatment services provided were deemed medically necessary.]

[If you have not entered into an agreement with the Insurance Company to allow offsetting of overpayment of a claim from your current/future claim submissions, this paragraph may be used.] According to California law, the insurer may offset overpayment of a pervious claim if 1) the provider fails to reimburse and 2) the provider has entered into a written contract specifically authorizing the plan to offset an uncontested notice of overpayment of a claim from the contracted provider's current claim submissions. (See 28 C.C.R. 1300.71.) I have never entered into a written agreement with [Insurance Company] authorizing it to offset an overpayment of a claim from my current claim submissions.

[If you have entered in an agreement with the Insurance Company to allow offsetting of overpayment of a claim from your current/future claim submissions, but do not agree with its decision, this paragraph may be used.] According to California law, insurers may offset only if 1) the overpayment was erroneous, 2) the error is not a mistake of law, 3) the insurer notifies the insured within six (6) months of the date of error, and 4) the notice clearly states the cause of

overpayment and amount due. (See 10 C.C.R. 2695.11.) [Insurance Company] must reimburse this claim because payment of the previous claim was correct. I reasonably relied on the [Insurance Company's] authorization and reimbursement rates for treatment services. [If the insurer did not provide notice or if the notice was not clear, then include that information here as well.]

On [date payment received], I received an Explanation of Benefits and a check in the amount of [total amount of monies paid for services] for the services I rendered to patient. Pursuant to the Explanation of Benefits, patient reimbursed me [total amount of copayment monies received from patient] for [his/her] share of the total balance. Since [Insurance Company] authorized and reimbursed for the treatment services I provided to [patient name], I reasonably expected to be compensated at the reimbursed rate for continuing to render such services to the patient.

According to California law, a plan may not modify or retract authorization after the provider renders the service in good faith and pursuant to the insurer's authorization. California Health & Safety Code Section 1371.8 provides that, "a health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility."

An error made on the part of [Insurance Company] or its employee is not a valid reason to demand a refund for overpayment. As a provider, I have no way of accessing [Insurance Company's] internal administrative information to determine authorizations and reimbursement rates for treatment services. Rather, I rely on information given to me by [Insurance Company] agents and employees.

Consequently, I, in good faith, reasonably relied on the information given to me by [name of agent], who is an employee of [Insurance Company], as well as the Explanation of Benefits and reimbursement check sent to me from [Insurance Company].

Thus, I respectfully request that this matter be promptly reviewed and reimbursed me in the amount in the amount of [amount], including interest. Please contact me for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when claim was denied because the plan is a self-insured welfare benefit plan.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter of claim denial dated [insert date of receipt of denial letter]. The claim was timely submitted on [date claim was submitted]. In its denial letter, [Insurance Company] provided the reason for denial was the client was treated by a licensed marriage and family therapist, a provider claimed to not be recognized by the plan. [Insurance Company] stated that it is a self-insured plan, which is governed by the Employee Retirement Income Security Act. [Insurance Company] believes that because it is governed by federal law, it may avoid compliance with California's "freedom of choice" laws.

[Provide a brief discussion of patient's treatment and the likely results if patient were to end treatment.]

Case law holds that ERISA preemption is not absolute. ERISA only pre-empts state laws that require the offering of a certain kind of benefit. *Rebaldo v. Cuomo* (749 F. 2d 133 (1984)) indicates that ERISA does not invalidate those state statutes whose effect on plans is simply tangential in nature. California law only tangentially affects the plan by requiring that certain licensed providers be reimbursed when they provide covered services. Since mental healthcare is a covered benefit under this plan, any of the providers named in the California Insurance Code should be reimbursed if they perform the covered services. (See California Insurance Code Section 10177.)

Further, Congress did not intend to have ERISA pre-empt state law regarding providers because the federal government does not license health care practitioners. Licensing is a well-recognized state function.

Thus, I respectfully request that this matter be promptly reviewed and [Insurance Company] reimbursed in the amount of [amount], including interest. Please contact me for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,
[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when the claim was denied because the plan was an out-of-state self-insured welfare benefit plan, which purchases excess or stop-loss insurance or which purchases a minimum premium policy.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter of claim denial dated [insert date of receipt of denial letter]. The claim was timely submitted on [date claim was submitted]. In its denial letter, [Insurance Company] provided the reason for denial was the client was treated by a licensed marriage and family therapist, a provider claimed to not be recognized by the plan. California Insurance Code Section 10177.8 specifically includes LMFTs in the law, which mandates "freedom of choice" for providers. However, [Insurance Company] stated that it is a self-insured plan, which is governed by the Employee Retirement Income Security Act. [Insurance Company] believes that because it is governed by federal law, it may avoid compliance with California's "freedom of choice" laws.

In reviewing [Insurance Company] plan booklet, everything about the plan appeared to offer a typical insurance contract. I was led to believe that [Insurance Company] was underwriting the total coverage because [use those indicia of insurer's involvement that apply, and others that may exist in your case:]

1. The plan booklet cover displayed [Insurance Company];
2. The insurance card issued to the patient indicated [Insurance Company], their address, and telephone number;
3. The payment for claims are on checks displaying the name of [Insurance Company];
4. Questions regarding coverage or claims are to be directed to [Insurance Company] and not patient's employer.

Thus, because everything about the plan appeared to be an insurance contract governed by California law, the patient and I both reasonably believed that the patient would have the freedom to choose the therapist of [his/her] choice.

In addition, the patient and I both understand that this plan is not totally self-insured. We understand [Insurance Company] writes a minimum premium policy for patient's employer. In a case entitled Michigan United Food and Commercial Workers Union v. Baerweldt, 767 F.2d 308, the U.S. Court of Appeals for the 6th Circuit ruled that ERISA did not preempt a state insurance law where the self-insured plan benefits up to an agreed upon amount and the insurance paid additional benefits. Even though this minimum premium policy has never paid any claims, case law confirms the applicability of state law in such instances. (See Northern Group Services, Inc. v. Auto Owners Insurance Company, 833 F.2d 85, 6th Circuit, 1987.) The court, regarding this case, also stated that even fully self-insured plans are not totally immune from traditional state regulation.

Thus, I respectfully request that this matter be promptly reviewed and [Insurance Company] reimbursed in the amount of [amount], including interest. Please contact me for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]

This sample appeal letter may be used when the claim was denied because the services were provided by an LMFT Registered Intern working under supervision.

[Letterhead]

[Date]

Appeals Department
[Insurance Company]
[Address]

RE: [Patient Name]
[Subscriber ID #]
[Group #]
[Claim #]

Dear [Mr./Ms./Appeals Department]:

I am in receipt of [Insurance Company's] letter of claim denial dated [insert date of receipt of denial letter]. The claim was timely submitted on [date claim was submitted]. In its denial letter, [Insurance Company] provided the reason for denial was the patient was treated by an LMFT Registered Intern.

The LMFT Registered Intern is employed by and working under my direct supervision. I am a licensed marriage and family therapist and my license number is [license #]. As the intern's direct supervisor, I am responsible for the treatment the patient receives. I initially determined that the intern is competent to treat the patient. This situation is no different than when a patient is being seen by an obstetrician to have conceive. The initial visit is with the obstetrician, and every time thereafter, the patient is seen by a nurse practitioner, yet the obstetrician receives reimbursement for those services. Since I am ultimately responsible as the employer and supervisor of the intern, I am requesting your reconsideration of the submitted claim.

Please contact me for any additional information you find necessary to complete my request. Thank you for your courtesy and cooperation.

Sincerely,

[Your Name], [Degree]
Licensed Marriage and Family Therapist
[License #]