

Appeals Checklist

If a prior authorization has been denied, the first step is to review the reason for denial and the attached appeal guidelines. Insurance companies follow similar rules for appeals but may have various processes to take.

C – Complete any required/additional forms needed for the appeal

U – Understand the reason(s) for denial

R – Review any insurance specific guidelines for the appeal

B – Be informed of insurance specific timelines for appeal

The checklist below can guide the patient, or your office sending a complete and thorough appeal request to the insurance company.

Remember to:

The appeal may require a supporting Letter of Medical Necessity (LMN) or appeal letter which includes:

- Patient medical history
Include the following: ICD-10-CM diagnoses, date of onset, diagnostic testing or imaging results, comorbidities
- Duration of time patient has had the diagnosis
- Medical necessity for the procedure
- Previously tried/failed treatments

Include additional documentation that extends beyond the initial submission for evaluation

Follow the payer specific process for appealing the initial denial (check pages following denial letter)

Include the payer specific appeal form when required by the payer

Adhere to the payer’s established guidelines for timely submissions

Reference payer policy that may apply including policy number, and detail out how the patient meets the requirements

Attach peer reviewed articles that you feel support your medical necessity

Indicate pertinent supporting medical documentation by circling sections for the reviewer