

Request for Information: Utilization Review Entity – Not Enough Information

Private Insurance and Medicare Advantage (HMO) Plans

From the [Authorized Representative](#)

Template Reference: URE #1

Use for: Private Insurance and Medicare HMO Plans

Use When: Reason for denial was that there was *not enough information* to determine medical necessity.

Who can send: Claimant has right to information, so Patient should sign “Patient’s letter” or, if you have been named as their authorized representative, you sign the “Provider letter.”

Send to: Utilization Review Entity or Health Plan, whichever made the adverse determination.

Requirement: Federal law requires the URE/Insurer to inform the claimant specifically about what information is needed for the claimant to perfect his or her claim.

Instructions: Send this letter to the entity that originally denied or partially denied the visits or *treatment you requested*. *This letter holds the entity making the adverse benefit determination* accountable for complying with state and federal laws when they deny covered benefits based on medical necessity. If the denial was based on benefit exclusions or limitations (covered benefits have been exhausted), this is not the appropriate letter to send.

If the UR entity refuses to provide the clinical review criteria or the medical rationale for their adverse decision, or they do not provide the requested information in a timely manner, you have cause to complain to your state Department (or Bureau) of Insurance (if the patient’s plan is a fully insured ERISA or individual/small group plan governed by state laws) and/or the regional office of the U.S. Department of Labor if the plan is a fully insured or self-insured employee health benefit plan (including Multiple Employer Welfare Arrangements (or “MEWAs”).

Provider as Authorized Representative Letter

PT Company Letterhead

Insert Date

[Name of Utilization Review Entity]

Attention:

Address

City, State, Zip

Delivered via [Fax or other process] to:

RE: Request for Information for Appeal of Adverse Benefit Determination

Participant: _____

Name of Health Plan:

Participant ID#: _____

[Other Reference Code, if any]: _____

Services Denied: (i.e. 6 physical therapy visits)

Date on Denial Letter: _____

To Whom it May Concern:

The above-named patient is being seen at our facility for physical therapy services. We received a Notice of Adverse Benefit Determination denying, in whole or in part, the medically necessary visits we requested pre-authorization for. We cannot carry out our treatment plan without knowing in advance whether the full number of visits we anticipate needing will be approved, therefore, the participant has appointed me as their Authorized Representative in a request for an expedited appeal from the Group Health Plan or Health Insurance Issuer. A signed Appointment of Authorized Representative form is enclosed.

Your Notice of Adverse Benefit Determination stated you did not have adequate information to determine the medical necessity of the request. Federal law requires you to inform the

participant/claimant within 24 hours about what information is needed to perfect the claim and why it is needed. You did not comply with this requirement so we do not know what additional information to submit to get approval for the rest of the visits we requested. Therefore, in order to have a full and fair review, we need you to provide the following items:

- A description of what additional information you require to make a finding that all the requested visits are medically necessary and an explanation of why such information is necessary.
- A copy of the clinical review criteria you used to determine that the total number of visits requested *was not* medically necessary.
- Copies of all documents, medical records and any other information relevant to the claimant's claim for benefits on which you based your adverse determination.
- An explanation of the specific medical and scientific reasons or clinical judgment for your adverse determination, applying the terms of the plan to the claimant's medical circumstances or indicating which provision in the benefit plan excluded coverage for the service requested.

Federal law requires you to expeditiously provide the above documents free of charge upon request. (See 29 C.F.R. Part 2560.503-1) Please fax these requested documents to us as soon as possible at _____.

Time is of the essence as we are requesting an expedited appeal in order to avoid detrimental interruptions in treatment.

Thank you,

[Name of Physical Therapist serving as Authorized Representative]

Enclosures