KNOW YOUR RIGHTS

What to Do When You're Denied Mental Health or Addiction Care

THE KENNEDY FORUM

INTRODUCTION

You're Not Alone

Families should never have to refinance homes or go into crushing debt just to get mental health care that a health plan is required to cover. But it happens. That's why it's essential to know your rights — and to understand that **help exists**.

If you're unsure where to start or feel overwhelmed, **start small**: request your denial in writing, file your appeal, and reach out to one of the organizations below. Each step matters.

Your Core Rights

- You have the **right to parity**. Mental health and addiction treatment must be covered on equal terms with medical care.
- You have the **right to know why** your claim was denied.
- You have the **right to receive that reason in writing.**
- You have the **right to appeal** the denial, both internally through your insurer, then externally through a third party.
- You have the **right to file a complaint** with your state or federal regulator.

What to Include in a Complaint

- All denial and appeal letters
- Medical records, provider support letters, or medical necessity letters
- Timeline of appeals
- A short summary explaining how this denial violates your rights (e.g., it's not parity-compliant, lacks clinical justification, etc.)

For a more comprehensive guide, see **The Kennedy Forum and NAMI's** Health Insurance Appeals Guide: A Consumer Guide for Filing Mental Health and Substance Use Disorder Appeals

FOUR-STEP GUIDE

1 Step One: Review Your Denial and Gather Information

Start by reading your **Explanation of Benefits (EOB) or denial letter** carefully.

When you receive a denial, you should also receive:

- The **specific reason** for the denial
- Instructions for **how and when to appeal**
- A deadline to file an appeal—typically **180 days** from the denial

Gather all necessary information. Keep everything — letters, emails, and notes from any calls with your insurer. Gather any necessary information such as diagnoses and/or treatment plans from your provider.

2 Step Two: File an Internal Appeal

This is your opportunity to ask your insurer to reconsider its decision.

Write a letter or use your insurer's appeal form

- Include your name, plan ID, claim number, date of service, the reason you believe it should be covered, and documentation from your provider
- Consider using this **sample appeal letter from NAIC** or the appeals template included in **this Patient Advocate Foundation guide** (see page 8).
- Submit by the deadline outlined in the denial letter

At a minimum, the written appeal should include:

- The individual's name, address, and telephone number
- The individual's insurance ID number, group number, and claim/document numbers
- The provider's name and the dates of services received
- A description of the service or supply
- A copy of the health plan's adverse benefits determination

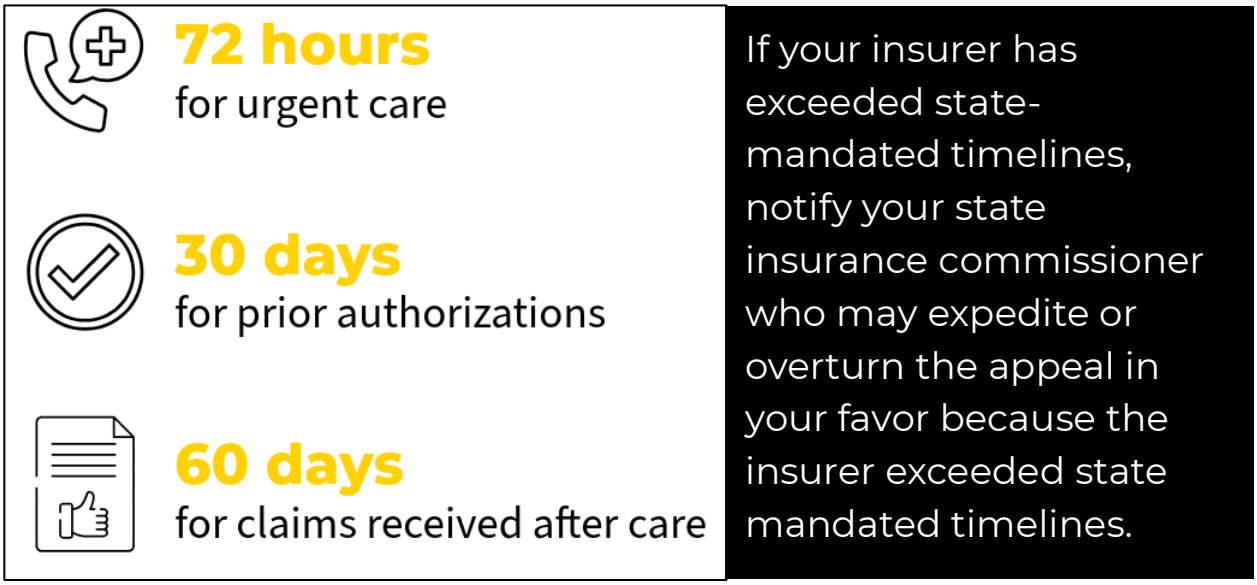
What to include:

For denials citing medical necessity:

- Work with your medical provider to gather information about medical necessity and any relevant information on your medical history and prior treatments to craft a **medical necessity letter**. Be sure to include prior treatments sought and outcomes, rationale for why the treatment you are seeking is medically appropriate.
- Clearly **site the service being sought** and **address the specific reason for denial** stated by the insurers. **Discuss what will happen without treatment** including information on the **generally accepted standard or level of care** for your condition(s). For example, for addiction care, cite ASAM criteria and the level of care and duration of care required using the ASAM criteria.
- Include any other evidence that you think may help your case, including journal articles or research supporting your claim(s).
- Enclose: denial letter, your provider's medical necessity letter, medical records, and any other supporting documentation.

Timelines:

While this varies by state, generally an insurer must respond within:



3 Request an External Review

If your internal appeal is denied, you have the **right to an independent review** by a third party.

Request an external review directly with your health plan which will trigger various timelines of required response.

The review may be managed by your state insurance department or federally certified independent review organization (IRO).

4 File a Complaint with a Regulator

If you believe your rights are being violated — or the appeals process fails — you can report it.

First, you must understand who regulates your plan to file a complaint:

Plan Type	File Complaint With
Self-funded employer (ERISA)	Local EBSA office (U.S. Dept. of Labor) *using their online form or call (1-866-EBSA)*
Fully insured employer or individual	State Department of Insurance
ACA Marketplace plan	State DOI or CMS
Medicaid / CHIP	State Medicaid Agency or CMS
Medicare Advantage / Part D	CMS/Medicare
Federal Employee Plan (FEHB)	Office of Personnel Management (OPM)

Find your regulator: NAIC Directory

RESOURCES AND HELP

Where You Can Get Help

The process can be overwhelming, especially for families navigating urgent or chronic care needs. Many states offer assistance with managing medical insurance denials through state insurance departments or Ombudsman programs. Free assistance from non-profit organizations may be available in your area as well.

Appeals Assistance & Navigation

- **State Consumer Assistance Programs**
- **Legal aid organizations**: Many states have legal services or protection & advocacy (P&A) agencies for health care and disability rights
- **Consider an organizations working on appeals:** a number of organizations specializing in mental health and addiction appeals take cases for a fee. This option may be helpful in preserving time, money, and energy in navigating successful appeals. An example is FixMyClaim.
- **Consider AI-generated appeals:** Numerous companies offer AI-generated personalized appeal letters for denied claims as a paid service.

Additional Tools and Strategies

Medical Necessity Letters

A well-crafted medical necessity letter from your clinician can be pivotal in overturning insurance denials. Cover My Mental Health provides medical necessity letter templates and guidance to assist clinicians in drafting these letters effectively.

Single Case Agreements (SCAs)

If no in-network providers are available, you can request a Single Case Agreement, allowing you to receive care from an out-of-network provider at in-network rates. Missing Piece offers advice on initiating SCAs.

Sharing Your Story

Your experiences can help others and influence change. The Kennedy Forum encourages individuals to share their stories about insurance obstacles, which can be instrumental in advocacy efforts. Share your story by contacting info@thekennedyforum.org with the subject line, *Sharing My Story*.

Key Laws That Protect You

Law / Rule	What It Guarantees
MHPAEA	Equal coverage for mental health and substance use treatment compared to medical/surgical care
No Surprises Act	Protects against surprise billing and improves transparency for emergency and out-of-network care
ACA	Requires coverage of mental health and addiction treatment as essential benefits
ERISA	Ensures employer-sponsored plans provide clear reasons for denials and appeal options

Local NAMI or MHA chapters are excellent resources for information and for finding a community of people who are navigating many of the same things you are. **Find your local NAMI chapter or MHA chapter for support.**

Additional Resources

Patient Advocate Foundation's Step-by-Step Guide, including their free training series, Health Insurance Denials and Appeals, Don't Take No for an Answer and Engaging with Insurers: Appealing a Denial.

Ask a Biller Webinar: Dealing with Insurance Denials YouTube