Favored
MEDICAL BILLING

Fax Number: 1.623.374.4592
(the 1 is required in front)
Email: info@favoredmedicalbilling.com
Phone: Kashuna at 623.322.0730

Appeals and Reconsiderations

The who, what, when, where, why, and how on writing a proper appeal.

Who:
Who should write the appeal? The patient should write the appeal. As a customer of the insurance company you have the right to request a review of the claim processing.

What:
What do I need to appeal? In order to send a proper appeal you need:

- A letter clearly stating that you are requesting a formal appeal or reconsideration of your claim
- Provider name in which who treated you
- Date of service (the date you received treatment)
- Billed amount (the amount in which the provider submitted for the service rendered)
- Claim number
- EOB

All of the this information can be found on the EOB copy that your company provided you or it can be obtained by calling your insurance company directly. Your provided may be able to provide limited information.

What:
What am I appealing? You are appealing the processing of the claim. The amount of money paid on the claim or lack thereof, or the non-payment of the claim altogether.

When:
When do I send in an appeal? The appeal should be sent within 60 days of the original processing of the claim.

Where:
Where do I send the appeal? The appeal should be sent to the claims address listed on the back of your insurance card.

Why:
Why am I sending in an appeal? You are sending in an appeal to request that your insurance review the way the claim was processed in hopes that they will reprocess the claim and allow additional monies to be paid out

How:
How do I follow up? You can contact the number on the back of card identified as member service and request the to speak with the claims department, once transferred you will inform them that you are checking the status of an appeal the was sent by yourself.

Key Points to use in your appeal:

- The appeal should explain in the most human manner why you are disappointed in the way the insurance has chosen to process the claim.

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- You should highlight the care you received and why choosing your specific provider was necessary in your care.

- And ultimately how as a patron you expect them to uphold their part of your signed agreement and cover the services rendered at the highest level of benefit.

Key Points to share with your provider:

- Inform your provider that you are going to appeal the decision that your insurance has decided to pay on your claim.

- Make the necessary payment arrangements to avoid collections

- Communicate regularly with your provider on the status of your appeal.

You may also request that your provider do a second level appeal using the information you have already provided to the insurance. This appeal should only be done if your appeal was denied.

Key Points to track the appeals process:

- Call your insurance company approximate 2 weeks after sending your appeal to ensure it was received.

- Keep a record of the date each phone call was made, the name of the customer service representative, and a reference number for the call.

You may contact me directly at any time and I can assist you in this process.