How to Deal with an INSURANCE DENIAL

MOVEMENT DISORDERS POLICY COALITION

Getting the medication you need can be a struggle. Insurance companies and pharmacy benefit managers can, through a number of tactics, delay or deny access to prescribed medication.

You can appeal your insurance company's denial. But you also have recourse when appeals don't resolve the problem. Every state oversees health plans and can act as a liaison between insurance companies and the people they serve. If you have been denied access to treatment, you can file a complaint.

Reasons You Might File a Complaint:

- As a prerequisite for the drug you've been prescribed, you're being required by your insurer or pharmacy benefit manger to first take a medication you already tried and failed with a previous health plan
- Your insurer or pharmacy benefit manager repeatedly refuses prior authorization or re-authorization requests for a medication that's FDA-approved for your condition
- Your insurer or pharmacy benefit manager repeatedly denies a request for access to a medication that's medically necessary for you but not covered by their formulary

When access becomes a problem, consider taking the following steps.

STEP 1

Try to resolve the issue directly.

First try to solve the problem by following your insurance company's appeals process. You must file your appeal within **six months** of receiving notice that your claim was denied. At the end of the internal appeals process, your insurance company must provide you with a written decision.

STEP 2

Request an external review.

If the insurance company's final decision is unsatisfactory, you have the right to take your appeal to an independent third party for review. This is called external review. See **this state list** maintained by the HHS's Center for Consumer Information & Insurance Oversight to learn more.

STEP 3

File a complaint with your state insurance department.

State-specific links for filing a complaint are available at www.movementdisorderspolicy.org/complaint

Be prepared to provide the following information:

- The reason for your complaint
- Your name and contact details
- The name of your insurance company, the type of insurance, your policy number and the state where the plan was purchased
- Information about your insurance claim, including claim numbers and dates
- Any documents with additional information you sent to the insurance company (like a letter or other information from your doctor)
- What you consider to be a fair resolution.

Most states are required to follow up in a defined period, usually 30-45 days.

FINAL STEP

Share a copy of your complaint.

The Movement Disorders Policy Coalition is tracking complaints related to care and treatment denials to help follow-up on systemic access challenges. Sharing your story will help other patients get access to treatment. Please email a copy of your complaint to: lcarterearly@allianceforpatientaccess.org

MOVEMENT DISORDERS POLICY COALITION

About the Movement Disorders Policy Coalition

The Movement Disorders Policy Coalition serves as a platform from which stakeholders, including health care providers and patients, can provide input on policy decisions impacting patient access to approved therapies and appropriate clinical care.