Template Letter: Provider to Payer to Request a Fast/Expedited Appeal of a Prior Authorization Denial

This template may be used by private practice physical therapists to appeal a prior authorization denial.

Insert the applicable information in brackets and create a letter to mail or fax, or an email to send.

Faxes may be sent to: 1-877-960-8235

REMINDER: Delete the header, these instructions, and any other bracketed language below prior to submitting your letter.

DATE

United Health Care Fast Grievance

P.O. Box 6103

MS CA120-0360

Cypress, CA 90630-0023

Re: Name of Patient

Plan ID Number:

Claim Number:

Provider Name:

Date(s) of Service:

Dear UnitedHealthCare Fast Grievance Team:

I am writing to request an expedited external review of your initial determination/denial of the claim for assessment, treatment, or services provided by [name of provider on date provided] as authorized under 42 CFR §422.566(c)(1)(ii), 42 CFR § 422.100(c)(1) and 42 CFR § 422.566(b)(3) and (b)(4) and the Medicare Appeals and Grievances Manual §40.4 (see <https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf>).

The reason for denial was listed as [reason listed for denial on the plan’s internal appeal determination], but I have reviewed my policy and/or discussed the treatment with my physical therapist provider and believe the treatment or service should be covered.

[Insert detailed information about the situation. Write short, factual statements. You do not need to resubmit documents that you sent for the prior internal appeal. If you are including new documents, include a list of what you are sending. For example:

· Reference and attach letters from the patient’s providers, including the treatment plan, statement of medical necessity, provider’s progress notes, etc.

· Reference and attach a copy of the internal appeal denial determination and the Plan’s EOB, if applicable.

· Provide a copy of the patient’s insurance card (if coverage is in dispute).

· Reference and attach proof of the patient’s diagnosis (if diagnosis is in dispute).

· Reference and attach published research, if applicable.

· Reference and attach any other new documents you wish to provide to support your appeal.]

Please send me a list of the documents being sent to the Independent Review Organization at the address below.

I am also independently sending a copy of this communication to Maximus, the Medicare Advantage appeals reviewer at:

Maximus

Medicare Managed Care & PACE Reconsideration Project

3750 Monroe Avenue

Suite 702

Pittsford, NY 14534-1302

Fax: 585-425-5292

I look forward to receiving your response as soon as possible.

Sincerely,

Signature

Typed Name

Address

Email address

Phone #