The Denial Playbook

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Your insurance said no. That is not the final answer. Most people never appeal a denial, and many who do appeal win. This playbook walks you through the exact steps, deadlines and words to use.

I'm Aaron M. Laxton, PhD, LCSW. I'm a licensed clinical social worker and a healthcare executive who has spent my career inside the systems I now explain on @aaronthesocialworker. I wrote this so you don't have to fight alone or guess. For more tools and updates, visit www.aaronthesocialworker.com.

How to use it: Read "First 48 hours" right away. Then find your plan type, follow the appeal steps in order, and use the scripts and templates at the end. Keep everything in one folder.

This playbook is general education, not legal or medical advice. Rules vary by plan and state, and your denial letter and plan documents control your specific deadlines. When in doubt, call one of the free resources at the end.

First 48 hours

Don't pay, don't panic, and don't accept a phone "no" as final. A denial starts a clock, so your first job is to stop it from running out on you.

- [ ] **Get the denial in writing.** If someone told you by phone, ask for the written notice. Your appeal rights and deadlines are in it.
- [ ] **Find your deadline and put it on your calendar.** Then set a reminder two weeks earlier.
- [ ] **Call your doctor's office.** Ask: "Did you get this denial too, and will you help me appeal?" Many offices have staff who do this every day.
- [ ] **Ask if it's urgent.** If waiting could seriously harm your health, ask your doctor to request an *expedited* (urgent) appeal. Those are decided in about 72 hours.
- [ ] **Start a folder and a call log.** Every letter, bill, portal message and phone call goes in it (log template at the end).
- [ ] **Don't pay a bill tied to the denial yet.** Ask the provider to put the account on hold while you appeal.

Decode your denial letter

Your denial letter is a map of how to win. Circle these six things before you do anything else.

1. **The exact service and date** that was denied.
2. **The reason** for the denial, in their words.
3. **The rule they used:** the plan provision, medical policy or clinical guideline cited. You have the right to see it.
4. **Your appeal deadline** and where to send the appeal.
5. **Whether urgent review is available.**
6. **Your plan type**, which decides whose rules apply (next section).

Common denial reasons, translated

What the letter says	What it usually means	Your best response
Not medically necessary	Their reviewer decided your care doesn't meet their criteria	Letter of medical necessity from your doctor that answers their criteria point by point
No prior authorization	Approval wasn't requested, or wasn't requested in time	Ask your provider to request retro-authorization or appeal; check if it was an emergency
Experimental or investigational	They say the treatment isn't proven	Published studies, clinical guidelines and specialty society statements
Out of network	The provider isn't in their network	Show no in-network option was available or timely; check surprise-billing protections
Step therapy / try another drug first	They want a cheaper option tried first	Records showing you already tried it, can't take it, or it would harm you
Coding or billing error	A wrong code or missing information	Ask the provider to correct and resubmit the claim; often the fastest fix

What the letter says	What it usually means	Your best response
Not a covered benefit	They say your plan excludes it	Read the exclusion word for word; it may not actually fit your situation

If the reason is vague ("does not meet criteria"), ask for the specific criteria in writing. Since January 2026, Medicare Advantage, Medicaid, CHIP and federal Marketplace plans must give a specific reason for denying a prior authorization for medical services.

Know your plan type

The type of plan you have decides your deadlines and who has power over your insurer. Find yours below before you write a single word of your appeal.

Plan type	How to tell	Who enforces the rules	Appeal path
Employer plan, **self-funded**	Plan documents say "self-funded" or "administered by"; ask HR	U.S. Department of Labor (EBSA), under federal ERISA law	Internal appeal, then external review
Employer plan, **fully insured**	The insurance company carries the risk; ask HR	Your state department of insurance	Internal appeal, then external review
Individual or Marketplace plan	You bought it yourself or on HealthCare.gov / a state exchange	Your state department of insurance	Internal appeal, then external review
Original Medicare	Red, white and blue Medicare card; you get a Medicare Summary Notice	Medicare (CMS)	Five-level Medicare appeal
Medicare Advantage or Part D	Card from a private company (Humana, UnitedHealthcare, Aetna and others)	Medicare (CMS)	Plan reconsideration, then automatic independent review

Plan type	How to tell	Who enforces the rules	Appeal path
Medicaid or CHIP	State Medicaid card or a Medicaid health plan	Your state Medicaid agency	Plan appeal, then state fair hearing

Not sure? Email HR and ask: "Is our health plan fully insured or self-funded?" The answer tells you whether your state can help or whether to call the Department of Labor. Government-employer, church and federal employee plans have their own rules; your plan documents spell them out.

The appeal, step by step

A strong appeal answers the insurer's exact reason with evidence, in writing, before the deadline. Follow these steps in order.

1. **Request your claim file.** Ask in writing for every document used to deny you: reviewer notes, the medical policy or guideline applied, and the reviewer's credentials. Employer plans must provide these free when you ask. Template at the end.
2. **Bring your provider in.** Ask your doctor for a *letter of medical necessity* that answers the denial reason point by point. A checklist for that letter is at the end.
3. **Ask for a peer-to-peer review.** Your doctor can request a call with the insurer's medical reviewer. Many denials are reversed on this call, sometimes before you file anything.
4. **Write your appeal letter.** Keep it short and factual: who you are, what was denied, why it's wrong, what you want. Attach your evidence and list each attachment. Template at the end.
5. **Send it so you can prove it.** Use the method on your denial letter: portal upload, fax with confirmation, or certified mail with return receipt. Keep a copy of everything you send.
6. **Confirm receipt and track the clock.** Call a few days later and confirm it arrived. Write the date in your log and calendar the date a decision is due.
7. **If they say no again, keep going.** Ask for the final denial in writing and move to external review (next sections).

Tip: You can name someone to help, like a family member, advocate or your provider. Most plans have an "authorized representative" form; Medicare uses form CMS-1696.

Deadlines at a glance

Miss the filing deadline and you can lose your right to appeal, so file early. The dates on your own denial letter control if they differ.

Plan type	File your appeal within	Plan must decide within	Next step if denied again
Employer, individual or Marketplace	180 days of the denial	30 days for care not yet received; 60 days for care already received; 72 hours if urgent	External review: request within 4 months
Original Medicare	120 days of your Medicare Summary Notice	60 days	Reconsideration by an independent contractor
Medicare Advantage	65 days of the denial notice	30 days for care not yet received; 72 hours if expedited	Sent automatically to an independent review entity
Medicaid managed care	60 days of the denial notice	Set by your state and plan; check your notice	State fair hearing: request within 120 days of the plan's decision

Sources: HealthCare.gov internal appeals, U.S. Department of Labor, Medicare appeals overview, 42 CFR 438.402.

External review and escalation

When your insurer denies your appeal, an independent reviewer can overrule it, and the insurer has to accept that decision. This is where many people win.

External review (employer, individual and Marketplace plans)

- **Deadline:** request it within 4 months of the final denial.
- **Cost:** free through the federal process, and never more than $25.
- **Timing:** decided within 45 days, or 72 hours or less if urgent.
- **Result:** binding on the insurer. If the reviewer sides with you, the insurer must pay.

- **Urgent cases:** you can request expedited external review at the same time as your internal appeal if waiting could seriously harm your health.

Medicare and Medicaid have their own independent levels (see the deadlines table).

Escalate while you appeal

These steps run alongside your appeal. They don't replace it.

Who	When to use them	How to reach them
Your employer's HR or benefits team	Employer plans, especially self-funded ones, where your employer is the plan	Email HR with the denial and ask them to raise it with the plan administrator
State department of insurance	Fully insured, individual and Marketplace plans	File a complaint online with your state's insurance department
U.S. Department of Labor (EBSA)	Self-funded employer plans; denied access to your claim file	askebsa.dol.gov or 1-866-444-3272
1-800-MEDICARE	Original Medicare and Medicare Advantage	1-800-633-4227
Your State Health Insurance Assistance Program (SHIP)	Free one-on-one Medicare counseling	shiphelp.org
Your state Medicaid agency or ombudsman	Medicaid and CHIP	Number on your Medicaid card or notice
Your U.S. representative's or senator's office	Medicare, VA and other federal programs when you're stuck	Ask for a caseworker; this help is free

Scripts and templates

Copy these, fill in the brackets, and keep a copy of everything you send.

Phone script: calling your insurer

> "Hi, my name is [NAME], member ID [ID]. I'm calling about a denial for [SERVICE] on [DATE]. Before we start, can I get your name and a reference number for this call?
>
> Can you tell me the specific reason for the denial and the exact policy or guideline you used? Please send me a copy of that policy and my full claim file in writing.
>
> What is my deadline to appeal, and where do I send it? Is an expedited review available?
>
> Can you note on my account that I am appealing?"

Phrases that work: "Please put that in writing." "What is the specific criterion I didn't meet?" "I'd like to speak with a supervisor." "Please note that in my file."

Claim file request

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[Date]

[Insurer name and appeals address from your denial letter]

Re: Request for claim file
Member: [Name]   Member ID: [ID]   Claim/Reference #: [Number]
Service denied: [Service] on [Date]

I am requesting a complete copy of all documents, records and other
information relevant to this claim, including reviewer notes, the medical
policy or clinical criteria used, and the name and credentials of each
reviewer. Please send these free of charge.

This request does not replace my appeal and does not waive my deadlines.

Sincerely,
[Name, phone, email]
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Appeal letter

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[Date]

[Insurer name and appeals address]
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Re: Appeal of denial — [Service] on [Date]
Member: [Name]   Member ID: [ID]   Claim/Reference #: [Number]

I am appealing your decision dated [date] to deny [service]. You denied
this because [reason, in their words]. This decision is wrong because:

1. [Reason 1, e.g., my doctor documents that I meet each criterion in
   your policy, see letter attached]
2. [Reason 2, e.g., I already tried and failed [drug/treatment] from
   [dates]]
3. [Reason 3, e.g., this treatment follows published guidelines from
   [specialty society]]

I ask that you approve [service] and pay the claim. [If urgent: Waiting
for a standard decision could seriously jeopardize my health. I request
an expedited review.]

Attached:
- Denial letter dated [date]
- Letter of medical necessity from Dr. [Name]
- [Medical records, studies, other evidence]

Sincerely,
[Name, phone, email]
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Call log

Date and time	Who you spoke to	Reference #	What they said	Next step and due date

Letter of medical necessity: what to ask your doctor to include

- [ ] Your diagnosis and how long you've had it
- [ ] The treatment requested and why it's needed now
- [ ] Treatments already tried, with dates and results
- [ ] What happens to you if you don't get it
- [ ] How you meet each criterion in the insurer's own policy, point by point

- [ ] Supporting guidelines or published studies
- [ ] Your doctor's credentials, signature and contact information

Where to get free help

You don't need to pay anyone to appeal. These resources are free:

- **Your provider's billing or prior authorization staff**: they handle denials every day.
- **Your state's Consumer Assistance Program or insurance department**: help with employer, individual and Marketplace plans.
- **U.S. Department of Labor**: askebsa.dol.gov or 1-866-444-3272 for employer plans.
- **Medicare**: 1-800-633-4227, and your local SHIP counselor.
- **Patient advocacy groups** for your condition: many offer appeal letters and case managers.

A denial is a decision made by a system, and systems can be challenged. Keep your folder, keep your dates, and keep going.

Keep going at www.aaronthesocialworker.com for new guides, tools and **Denial Decoded** breakdowns. And follow **@aaronthesocialworker** on TikTok, Instagram, YouTube and Facebook.

Sources

- HealthCare.gov: Internal appeals
- HealthCare.gov: External review
- U.S. Department of Labor: Filing a Claim for Your Health Benefits
- CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)
- WTOP: How to appeal a denied Medicare claim (Aug 2026)
- 42 CFR 438.402: Medicaid managed care appeals