

Your Right To Appeal A Health Plan Decision



If your health plan denies coverage for a service or treatment, you have the right to appeal. This includes denials for services deemed not medically necessary, experimental or investigational, part of a clinical trial, or related to the treatment of a rare disease.

Step 1: File an Internal Appeal

When your health plan denies a request for care, it must send you a notice call and an Initial Adverse Determination. This letter explains:

- The reason your request was denied
- How long you have to file an appeal
- Where to send your appeal via mailing address, fax number, and/or online submission

You or your designee can submit an internal appeal directly to your health plan within 180 days. Be sure to follow the instructions and deadlines outlined in the denial letter.

Denied Referrals to Out-of-Network Providers

If your health plan denies a pre-service referral to an out-of-network (OON) provider, they must inform you of the reason for the denial and provide the names of in-network providers with appropriate training and experience who are able to perform the requested service.

If you believe that no in-network provider can meet your specific health care needs, you have the right to an internal appeal of the denial. Your appeal must include a written statement from your attending physician that explains:

- In-network providers do not have the necessary training and experience to treat your condition, and
- An OON provider with the appropriate training and experience is available to perform the service.

Step 2: Request an External Appeal

If your internal appeal is denied, your health plan must issue a Final Adverse Determination (FAD). Once you receive this notice, you have the right to request an external appeal through the New York State Department of Financial Services.

An external appeal is conducted by an independent medical expert who is not affiliated with your health plan. You must file the request within 120 days of receiving the FAD.

Appeal Fees

- Health plans may charge individuals \$25 per appeal, with a maximum of \$75 per year.
- This fee is waived for individuals enrolled in Medicaid, Child Health Plus, Family Health Plus, or if the fee would pose a financial hardship.
- Health plans may also charge providers \$50 per appeal. This fee is refunded if the denial is overturned.

More Information?

To learn more about your rights or to file an external appeal, visit dfs.ny.gov/externalappeal or scan QR code:

