Date

Insurance Plan Administrator
Address

ATTN: Plan Administrator, Employee Health Care Plan

RE: Plan/Group ID #
Member ID# Name
Claim Denial dated XXXXX

Dear Plan Administrator:

We received a letter dated XXXXX from Third Party Claims Administrator denying [our request for/coverage of] [describe service(s) and date(s) of service].

The denial letter identifies "medical necessity" as the basis for denial, but the notice does not provide enough information for us to effectively appeal the adverse decision.

The denial letter issued by Third Party Claims Administrator does not meet the ERISA notice requirements set forth in 29 U.S.C. § 1133, and more specifically enumerated in 29 C.F.R. § 2560.503-1(g)(1) as follows:

"The notification [of benefit determination] shall set forth, in a manner calculated to be understood by the claimant—

> (i) The specific reason or reasons for the adverse determination;
> (ii) Reference to the specific plan provisions on which the determination is based;
> (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary…"

The denial letter, a copy of which is attached hereto, references medical necessity as grounds for the claim denial, but fails to identify any specific plan provision upon which the determination is based.

In addition, the denial letter states that additional information may be submitted to support the medical necessity of the claim, but gives no description of the nature of information that would be regarded as relevant or why such additional material would be necessary.

The purpose of ERISA's notice and disclosure requirements is to ensure that when a claimant appeals a denial to the plan administrator she will be able to address the determinative issues and have a fair chance to present her case. There is simply no way that the determinative issues in this case can be identified from the content of the denial letter.

Further, when a benefits determination is based upon medical necessity criteria, federal regulations explicitly require that the determination notice provide "either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request." 29 C.F.R. § 2560.503-1(g)(1)(v)(B).

The referenced denial letter fails to meet either of these two regulatory requirements.

Please provide an explanation of the manner in which the medical information provided to date fails to support the medical necessity of the requested services.

Please identify the specific provisions of the Summary Plan Description relied upon as grounds for the benefits determination.

If any internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, please provide a copy of the applicable plan document and identify the specific provision(s) of that document relied upon as grounds for the benefits determination.

Please note that ERISA requires the provision of requested plan information, including internal benefits determination criteria, within 30 days of the date of a written request. A Plan Administrator may be liable for penalties of up to $110 per day of delay in responding to a request for plan information.

We look forward to your prompt response to this request. The requested information may be forwarded to the contact information provided below.

Very truly yours,

Name
Relationship
Contact Information