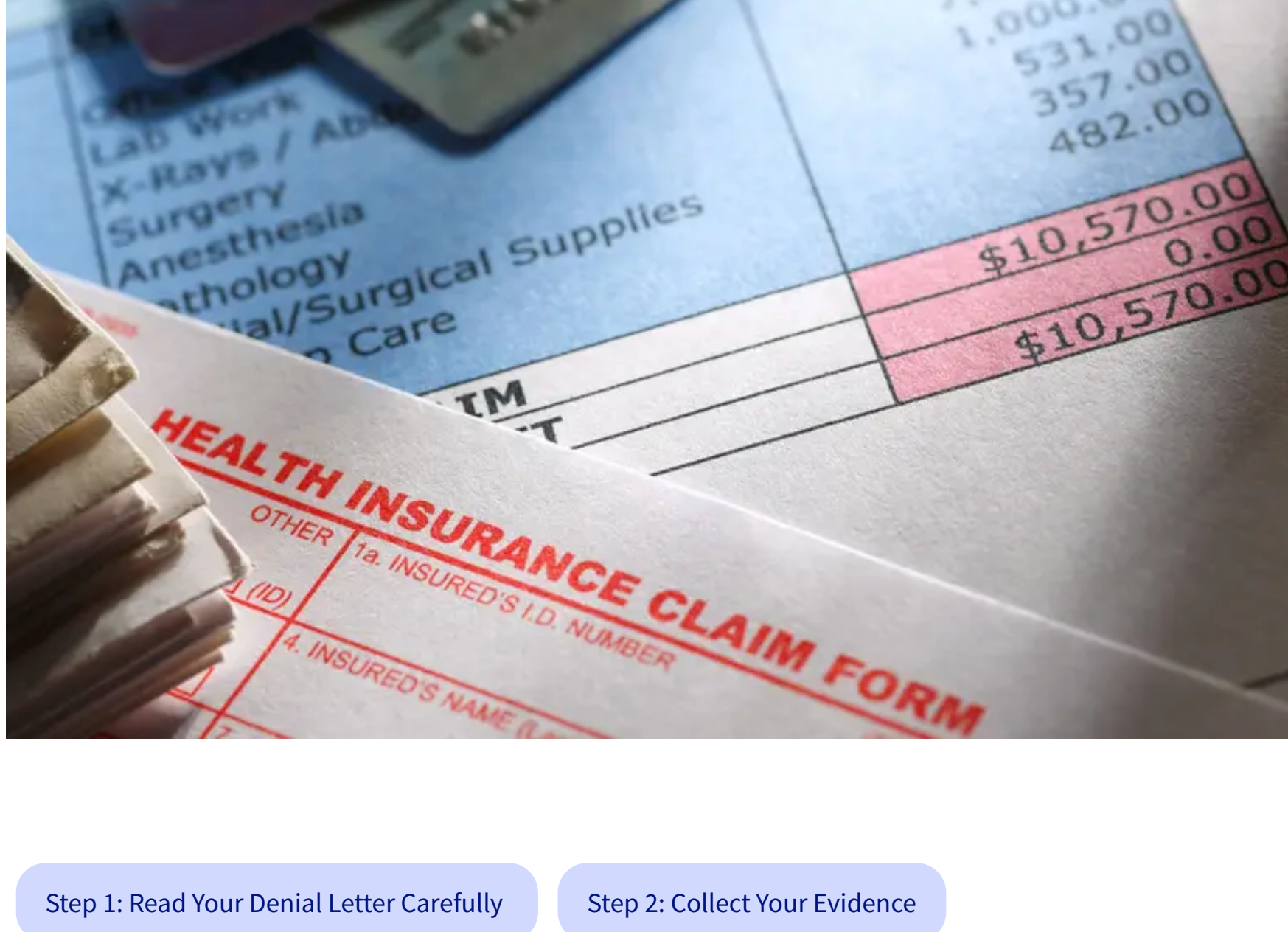




# What to Do When Your Claim Is Denied

By **Beth Braverman**Medically Reviewed by **Sarah Goodell** on January 25, 2026

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Learning that your health insurer has decided not to cover medical care that you've already received — or desperately need — can add stress to an already difficult time. But before you panic, you should know that their decision is not yet final.

You have the legal right to appeal an insurance denial for benefits or services that you and your doctor believe are medically necessary. And you could have a solid chance of winning your case. Success rates for such appeals range from 44% to more than 80%, depending on the type of insurance you have.

“It’s ... important to know about that appeals process because a lot of people don’t realize they have that right.”

Louise Norris, health policy analyst

To get your insurers to reconsider, you'll need to follow a formal appeals process that may include both an internal and an external review of your claim. You typically have 180 days to file an appeal. But Gail Trauco, a patient advocate and author of *Medical Bill 911 Handbook*, recommends getting started quickly.

“I would start it within 10 days of when you get that denial letter,” she says. “The longer you wait, the more they’re going to wonder why you think you need [the medical treatment] or why it should be approved.”

Taking the following steps may save you hundreds or thousands of dollars on the medical care that you need:

## Step 1: Read Your Denial Letter Carefully

Your insurer will let you know in writing when they have denied a claim, either to pay for services you've already received or to deny prior authorization for future services. You'll get this notice via snail mail, but you might also be able to find it in your insurer's app or web portal. It's common to feel emotional when you get such a letter, but you want to make sure you're clear-eyed when figuring out your next steps.

“Lay [the letter] down and wait two or three days until you feel a little less overwhelmed,” Trauco says. “Come back and pull it out and carefully review it.”

This letter contains important information you need to know, including:

**The reason for the denial.** Your insurer must tell you why they've denied your claim. For example, they may claim that the treatment was experimental, not medically necessary, or not covered under the terms of your plan. Sometimes insurers deny a claim because it requires “prior authorization” or they want you to try a different treatment first.

**How to appeal the ruling.** The letter must also provide detailed instructions on how to submit an appeal and what it must include, although you can also typically find this information on your insurer's website.

Sometimes the denial simply reflects an error in the claim, such as incorrect coding or missing information. Make sure that all the facts included in the letter are accurate.

If you have questions about the denial letter, call your insurer for a detailed explanation. You should also contact your health care provider's billing department to check for errors made during the claim submission process.

“Some folks find that having a three-way call with their medical billing office and the health plan, with everyone on the phone at the same time, can be helpful, just to get everyone on the same page,” says Louise Norris, health policy analyst for Healthinsurance.org. “Because sometimes there are just errors or miscommunications.”

Write down the names and titles of everyone you speak to and the dates and times of these calls. Follow up your calls with an email detailing the call and save a copy of that email.

## Step 2: Collect Your Evidence

You need to provide proof to your health insurance company that they made a mistake in denying your claim. Start by collecting all your medical records. This includes relevant test results, treatment history, and doctor's notes. Your doctor's office can provide this, but you may also be able to access it through your online patient portal.

### Items to Include in An Insurance Denial Appeal Letter

- Your name and policy number
- Contact information for you and your doctor
- Specifics on the denial reason

Next, you'll need a letter of medical necessity from your health care provider. This letter should explain why the specific treatment is essential for your condition. You might also put together supporting evidence of the treatment's effectiveness. This can be published medical journal articles, clinical

practice guidelines, or other research.

Finally, you'll need to write a concise letter explaining the situation to your insurer.

“Be specific,” Trauco says. “They don't want a six-page letter. Give them two very well-written paragraphs and your supporting documentation.”

The letter should include your health history and explaining why the denied service is necessary. You can bolster your argument with language from your policy and point to your attached evidence.

## Step 3: File an Internal Appeal

In many cases, your doctor will file this appeal on your behalf. Hospitals and military clinics often have a dedicated staff of patient advocates to help you through the process, but it may not be as quick as you would like.

“You might have to schedule a time [to discuss the issue] because they're very busy with patients, and you aren't the only person with a medical billing problem,” Trauco says.

If you work for a large employer, you may also have access to a patient advocate through your workplace benefits. But sometimes you'll have to either do the legwork yourself or pay for a private patient advocate.

While you may be able to mail or fax your documents to the insurer, using their online portal to upload your documentation will typically get you a faster response. When sending physical documents to your insurer, send copies and keep the originals.

Your insurer will have to let you know their decision within 30 days for services you haven't received yet and 60 days for services already received. For time-sensitive situations where delay could negatively impact your health, you can request expedited review, which requires a response within four business days.

## Step 4: Seek an External Review

If your insurer denies your internal appeal, you can request an external review. This is your final chance at getting the decision overturned through the appeals process.

You have four months after receiving a final denial notice to petition for a third-party reviewer to examine the case, typically through your state department of insurance.

“The instructions for doing this, for what you need to do for your specific plan in your state, will be in the denial letter you get from that internal appeal,” Norris says. “But it's more likely the patient will need to initiate that process.”

Your request for external review should include all the same documentation you used for the internal view. The external reviewers must make their decision within 45 days of receiving the request. If the case is urgent, you can request an expedited review, which requires a response within 72 hours. By law, your insurer must abide by the decision made by this third-party reviewer.

## Step 5: Accept the Decision

There are few options to reverse your insurer's decision if the third-party reviewer sides with the insurer. That said, if you believe the denial was unjust, you might consider checking with an attorney specializing in health insurance. They can help to see if you have grounds for a lawsuit.

### Important to Know

If you have Medicare or Medicaid, there may also be other, more complex appeals processes beyond the standard external review.

Otherwise, you'll need to decide if you want to move forward with the treatment, with the understanding that you'll pay the bill out of pocket. For services you've already received, you may be able to work with your provider to negotiate a lower total price and a payment plan that allows you to repay the debt over time.

## Steps to Take to Prevent a Denial

Going forward, you can reduce the risk of future denials by spending some time learning the terms of your plan, Norris says. That includes understanding which services need prior authorization and making sure you receive care from in-network providers whenever possible.

“There are definitely things that people can do on the front end to minimize the risk of claim denials,” Norris says. “But it's also important to know about that appeals process because a lot of people don't realize they have that right.”

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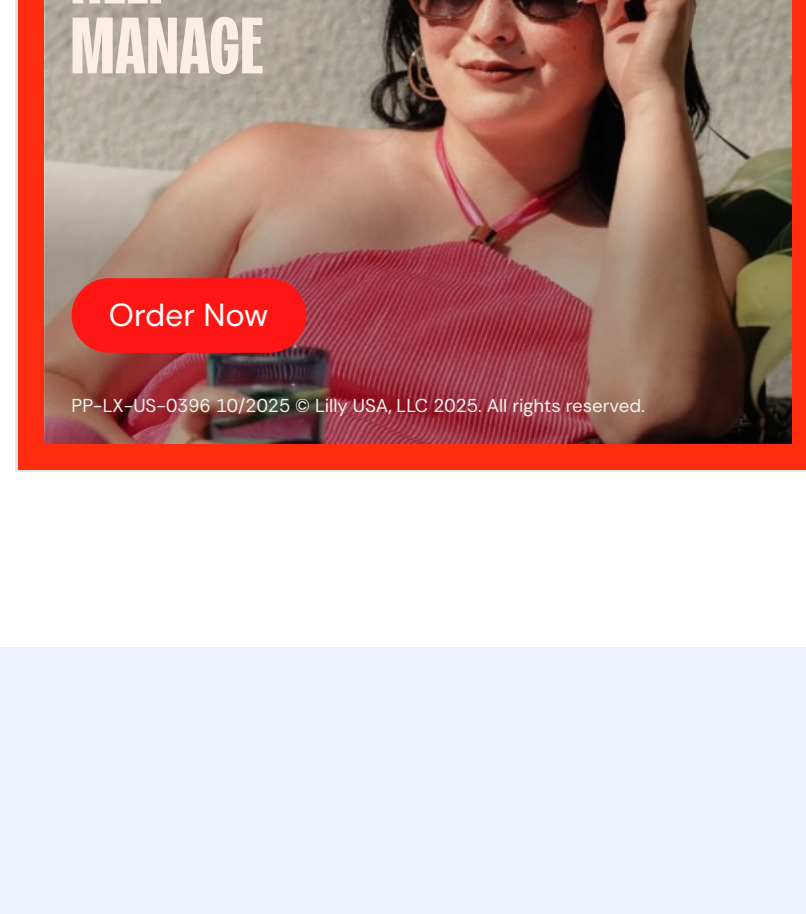
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