Exercise your right to appeal your health plan's decision!

It can feel like the whole world is against you if your prescription is denied. It shouldn't. You are not alone.

So, what do you do if you get denied?

First, take a deep breath. There are many reasons insurance companies deny treatment, such as errors in documentation or insurance coverage issues—none of which are your fault! In fact, there are over 300 million (yes, MILLION) requests for Prior Authorizations of prescriptions each year, and millions of these result in denials that can be challenged in a formal appeals process.

Second, you need to understand why your prescription was denied.
If you haven't already received it, you can request a denial letter from your insurance provider. This will explain the reason for the denial of coverage and the process to follow for making an appeal.

Third, by law you have the right to appeal a health plan decision.*
There are 2 different types of appeals you should be aware of; talk with your Hub Case Manager about how to proceed with each one:

- An **internal appeal or reconsideration** is where you request that your insurance company conduct a full and fair review of its decision. To do this, you can either call your plan directly or you can submit an appeals letter.
- If your internal appeal is denied, an **external review** is where you appeal your insurance company's final decision to an independent third party for review.

Here's some advice for working directly with your insurance company.

- If you get frustrated, stay calm and stand up for yourself.
- Insurance company employees can be very busy. Call or email often until you get a response, and take notes during phone calls.

> There's a team around you to help advocate for your care. But you are your *own* best advocate. Working together with your doctor's office, insurance company, or Hub Case Manager, there are ways you can help to try to overturn an insurance denial.

*Under the Affordable Care Act, patients have the right to appeal decisions made by health plans created after March 23, 2010.

Let your voice be heard!

Your Hub Case Manager will contact you to confirm if your prescription has been denied and provide instruction on how to start the internal appeals process with your doctor's office. Your doctor's office may write a Letter of Medical Necessity, or LMN, to appeal the decision. The LMN will list the medical reasons why you were prescribed the medicine and why your doctor feels it is the right treatment for you.

What can you do?

You can also write your own letter to go along with the doctor's LMN. Your letter can make a powerful statement in the appeals process and gives you an opportunity to tell your story.

A good appeals letter includes*:

- Details about your disease to educate the insurer. Remember to give examples of how it impacts your job, your family, and your everyday life. For example, mention how your disease has limited your activity or your ability to work, if that is the case
- Your personal medical history to show other therapies you have tried that did not work for you
- Circumstances that make your case special
- Any other information related to your reason for denial

Let's write this letter!
We have included space for all the above information in an appeals template. It's a Word document that's ready for you to fill in with the details about your disease. Adding emotion and passion to your letter can be a powerful way to make your case. The template is included with the materials from your Hub Case Manager. This is your chance to advocate for yourself and tell your story!

IMPORTANT: Keep your approval timeline in mind! When you have finished your letter, send it to your doctor's office; they will make sure it is part of the internal appeals/reconsideration review.

Remember, you also have a team of supporters at Mallinckrodt, including a Nurse Navigator and your Hub Case Manager, who would be more than happy to help you during the appeals process journey.

*The summary above represents typical information that insurance carriers require in order to render a coverage decision. Insurance carriers could require more or less information than what is included in this outline. Following these suggestions does not guarantee insurance coverage for you. The summary above is provided as a reference only; your letter should align with your clinical records and your personal treatment history and medical needs.

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