

YOUR GUIDE TO FIGHTING BACK

How to Appeal a Denied Health Insurance Claim

A plain-English cheatsheet for overturning a denial — step by step, in your own words. From the team at Healthvocate.

~1 in 5
in-network claims denied

<1%
of denials are appealed

~4 in 10
appealed denials overturned

A denial is not the end — it's the start of a process insurers count on you skipping. Most people never push back. When they do, a large share of denials get reversed (**KFF**). Here's exactly how to be one of them.

The 7 steps

- 1 Read the denial — find the reason.**
Your denial letter or Explanation of Benefits (EOB) states a reason, usually with a code. That reason is your roadmap: everything you write should answer it directly.
- 2 Find your deadline — today.**
Plans set time limits to appeal (often around 180 days for an internal appeal, but it varies). Mark the deadline the moment the denial arrives — missing it can end your options.
- 3 Gather your evidence.**
Collect the denial letter/EOB, your plan's Summary of Benefits and Coverage, relevant medical records, and — for a medical-necessity denial — a letter from your doctor explaining why the care is needed.
- 4 Identify the denial type.**
Most denials fall into a few buckets, each with a different counter-move (see the decoder below). Naming the type tells you which evidence actually wins.
- 5 Write the internal appeal.**
State who you are and the claim/denial reference, say plainly why the denial is wrong, attach your evidence, and make a clear ask: "I request this denial be overturned and the claim paid." Keep it factual and cite your plan's own language.
- 6 Submit it — and track everything.**
Send it the way your plan requires. Keep copies and proof of submission, and note the date you sent it and when a decision is due back to you.
- 7 If denied again, request external review.**
After internal appeals, you generally have the right to an independent external review by a third party not affiliated with your insurer. Your denial letter and your state insurance department explain how.

The denial decoder

Denial reason	What it usually means	Your counter-move
"Not medically necessary"	The insurer says the care isn't justified.	Get a letter of medical necessity from your doctor citing clinical guidelines and your history.
"Prior auth not obtained"	Approval wasn't requested before the service.	Ask your provider to request authorization (sometimes retroactively) and document the urgency.
"Out of network"	The provider isn't in your plan's network.	Show there was no adequate in-network option, an emergency, or request a network exception.
"Experimental / investigational"	They consider the treatment unproven.	Cite FDA status, published evidence, and that it's standard of care for your condition.
"Coding or billing error"	The claim was coded or submitted wrong.	Have your provider's billing office correct the code and resubmit the claim.
"Insufficient information"	They say records are missing to decide.	Submit exactly the documentation they ask for — nothing missing.

Deadlines & your rights

Internal appeal: often within ~180 days of the denial.

Urgent care: you can request an expedited appeal (often decided in ~72 hours).

External review: an independent third-party review after internal appeals — its decision binds the insurer.

Many of these come from federal protections, but exact rules vary by plan and state — confirm with your plan documents and state insurance department.

Common mistakes

- Missing the appeal deadline.
- Arguing with emotion instead of evidence.
- Skipping the doctor's letter on medical-necessity denials.
- Giving up after the first denial (external review exists).
- Not keeping copies and proof of submission.

Don't face the blank page alone.

Healthvocate reads your denial, identifies the type, and drafts a citation-backed appeal letter in minutes. You review it, sign it, and send it — you stay in control of every word. Start free at healthvocate.com.

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