PLAN PARTICIPANT REQUEST FOR

MEDICAL NECESSITY CRITERIA UNDER MHPAEA ONLY

[Insert name of plan participant]

[Insert address of plan participant]

[Insert email or other contact information, if desired]

[Insert date]

[Insert name of appropriate contact at plan]

[Insert title]

[Insert mailing address]

Dear Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

I am a current or potential participant in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [health plan].The Mental Health Parity and Addiction Equity Act of 2008 and Final Rules (29 C.F.R. §2590.712(d)(1)) permit current and potential plan participants to request a copy of the medical necessity criteria used by the plan to make determinations regarding mental health and substance use disorder benefits offered under the plan.

I hereby request a copy of the medical necessity criteria used by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[health plan] to make determinations regarding mental health and substance use disorder benefits available under the plan for the treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [diagnosis or diagnoses]. In addition, please provide any information you have regarding the processes, strategies, evidentiary standards, and other factors used by the plan in applying the medical necessity criteria to mental health and substance use disorder benefits available under the plan.

Please forward this information to the following address as soon as possible, but in no event later than 30 days from the date of this request:

[Insert name]

[Insert mailing address]

If the addressee listed above is not the health plan or a plan administrator authorized to respond to the above request, please provide the correct name and contact information for same.

Thank you very much for your assistance in this matter.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

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