AUTHORIZED REPRESENTATIVE REQUEST FOR REASON FOR DENIAL

[Insert name of psychiatrist]

[Insert address of psychiatrist]

[Insert email or other contact information, if desired]

[Insert date]

[Insert name of appropriate contact at plan]

[Insert title]

[Insert Mailing address]

**Re: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [plan participant]**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [identifying information regarding claim denial or**

**adverse action]**

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

I am writing on behalf of the above-named individual, who is a plan participant in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [name of health plan] and has received an adverse benefit determination with respect to mental health or substance use disorder benefits covered under their plan. Pursuant to the enclosed memo, the plan participant has designated me as his [or her] Authorized Representative.

As you may be aware, regulations promulgated under both the Mental Health Parity and Addiction Equity Act (MHPAEA) (29 C.F.R. §2590.712(d)(2)) and the Employee Retirement Income Security Act (ERISA) (29 C.F.R. §2560.503-1) require that health plans provide plan participants with a written reason for any denial of reimbursement or payment for services.

As Authorized Representative of the above-named individual, I hereby request a written notification of the reason or reasons for denial of reimbursement or payment for mental health or substance use disorder services rendered to the above-named individual. As required by law, the notice of denial must include the specific reason for the denial and the relevant denial code, including the meaning of the denial code and a description of the standards used in denying the claim, with a reference to the specific plan provisions relied upon. For denials based on medical necessity determinations, the plan must also provide an explanation of the scientific or clinical judgment used to make the decision, applying the terms of the plan to the specific medical circumstances in question.

Please send this information to me at the following address:

[Insert name]

[Insert mailing address]

[Insert email address if you would like to receive a copy of the information electronically]

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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