FAX

[DATE]

Via FAX [FAX Number]

[Insurance Company and/or Managed Behavioral Health Company]

[Member Services Department or other applicable department]

[Address, if needed]

Dear [Member Services or other applicable department]:

My name is [your name] and I am insured under policy #[insert policy #] and group #[insert group #]. My plan is governed by federal mental health and addiction parity laws.

I am currently a patient of [insert name of your mental health provider]. I hereby request a copy of the medical necessity criteria and specific reasons for denial on which reimbursement is denied for my treatment services at the following level(s) of care:

* Residential
* Partial hospitalization
* Intensive outpatient
* [Insert treatment or service if not any of the above- otherwise DELETE]

I have paid for this benefit and [insert name of your mental health provider] is licensed by the state of [insert state] [and accredited, if applicable] to provide these treatment services. My attending physician has admitted me to this/these level(s) of care and is recommending my continued treatment. I am in dire need of these treatment services and they are covered by my benefit plan and should be paid for.

I request that you immediately send the medical necessity criteria and specific reasons for denial used to reach a different medical decision than my treating physician. At your earliest convenience, please send this information to my attention at fax # [insert #]. If you would like to speak with my provider, please contact [insert name of applicable care provider contact].

Sincerely,

[Your Name]