



Using Your Insurance Coverage

Insurance policies often have complicated language that leaves you wondering what really is covered in your plan. Here are a few tips to help you use your policy to promote and maintain your health, and the health of your families. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered by your plan, when possible.

Understand Your Benefits

If you purchased insurance through an employer, you probably received a basic guide to the plan. This material usually does not have definitions or great detail about your coverage. That information is in the Certificate of Insurance. You can call your employer and request a copy. If you purchased insurance on your own and did not receive this certificate, call your insurance broker and request it.

The Certificate of Insurance explains information in greater detail. For example, if the general description states that you are entitled to 120 visits of home nursing a year, you won't know from that information what the definition of "visit" is. That information is in your Certificate. It might define a visit as a day, four hours, eight hours, or something else. You need to know this before planning how to use that benefit.

There are a few basics you always need when seeking information about your insurance: Know your policy number and enrollment code and include them with all inquiry and correspondence with your insurance company whether written, by phone, or email. You may be asked for the group or employer name and number.

Claims and Denials

You will receive an EOB (Explanation of Benefits) for each claim filed with your insurance company. This form will provide information on each claim, whether or not it was paid, and how much was paid. If the claim was not paid, there will be a reason listed on the form. Read this paper carefully, because sometimes only a portion of the bill will be paid by the insurance company and the rest is your deductible or co-pay and is your responsibility. The EOB also contains information on appealing denials.

Most times, the provider will file claims for you when they provide the treatment. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, your insurance company won't pay the bill. This is called "denying the claim." When a claim is denied, or you are trying to clarify coverage before treatment (pre-authorization), you may need to contact your insurance company

directly. When dealing with your insurance company, keep a record of all phone calls including date, time, name of person you spoke with and the information they provided you. Never take “NO” from someone who does not have the authority to say “YES”. Always submit a claim in writing and get a denial in writing. You cannot appeal a phone call, but you can appeal a written denial.

Preparing to Appeal

Know your health plan’s claims appeals process so you can gather the information required by the health plan. Most Companies have a timeframe in which you must file your appeal. Look for the following information:

- The health plan’s rationale for the denial (on the EOB)
- Your benefits under your plan in as written in the in the Insurance Certificate, not just in the summary of benefits

If the claim is being denied because the service is not a covered benefit:

- Review the contract language and if it is listed as a benefit, submit the page with you appeal letter, and
- Ask your physician to prepare a letter in support of coverage

If the claim is being denied because the service is not medically necessary:

Determine if the service is a recognized treatment for your condition, and

- That the service was or is being performed for a medical reason
- Is usual and customary treatment for your condition, and
- Is ordered by a licensed physician (if required)

The Appeal Letter

Prepare an Appeal letter that includes: the Patient’s Name, Subscriber’s Name, Health Plan Identification Number, Date of Service, and Reason why you are appealing the claim. Gather the necessary supporting documents, address the appeal letter to the appropriate health plan representative, and send the letter and documents via certified mail, return receipt requested.

- **After the Appeal:** Follow up with the health plan representative regularly to check on the status of the appeal. Keep copies of all documentation, all people you speak with and date and time. Continue to appeal claims denied by the health plan as it may take more than one appeal to reverse a health plan’s denial.
- **Complaints:** Every state has a state insurance commissioner or a state commission on insurance that advocates for and investigates complaints, assuring that your claims are not being denied unfairly.
- CT State Insurance Department Commissioner #: (860) 297-3800
- CT Office of the Healthcare Advocate #: 1-866-466-4446
Email: Healthcare.Advocate@ct.gov

Don't Forget To Say Thank You!!”

We often get caught up in the appeals/denials process. We forget to try and build relationships with staff at the insurance plans. When something is authorized and paid for, like a wheelchair, send a thank you, with a picture of your child in the chair. Tell them what a difference it made. The next time you need help, they will remember you.



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