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The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School Los Angeles

CALIFORNIA: A CONSUMER'S STEP-BY-STEP GUIDE TO NAVIGATING THE INSURANCE APPEALS PROCESS

INTRODUCTION

This handout is a step-by-step guide to the internal and external appeals processes in California for health insurance for individuals with cancer whose insurance companies have denied in full a particular treatment based on medical necessity or experimental treatment.

Before beginning the process of appealing to an insurance company, it is important for individuals to remember that they have the following rights:

(1) A right to information about why a claim or coverage has been denied;
(2) A right to see and respond to all information used in the internal appeal decision; and
(3) A right to an independent review (also called an external appeal).

It is also important to remember that a consumer's rights regarding how to proceed with an internal and external appeal depend on the specific policies of the insurance company, the laws of California, and federal law.

HEALTH INSURANCE APPEALS

Before You Begin: It is important to familiarize yourself with the following health insurance definitions.

- Health plan: The commonly used term for all types of health insurance and health plans (i.e. HMO, PPO, and POS plans)
- HMO (health maintenance organization): Requires that of a patient's care be arranged through the patient's primary-care physician, who will refer the patient to specialists, therapists, etc. that are part of that HMO's network.
- PPO (preferred provider organization) plan: Allows the patient to use any providers (hospitals, doctors, and therapists) of their choice, but the patient will pay less for services provided by health care providers that are part of that PPO network.
- POS (point-of-service) plan: An HMO that allows patients to obtain services from health care providers who are not part of the immediate HMO network, but the patient will pay less for services from providers within the network.

- Employer-sponsored health plan: A health plan that an individual enrolls in through their work. The employer generally makes a contribution toward the cost of coverage, and the employee pays for the remainder of the cost of coverage.
- Individually purchased health coverage: A health plan that an individual purchases on their own directly from a health plan. The individual is responsible for paying the entire premium on their own. State law governs both the internal and external appeals process for individually purchased health coverage.
- *Self-funded* employer-sponsored health plan: When an employer pays for the health care costs of its employees directly rather than purchasing insurance from an insuring organization. Often, self-funded plans process employee claims through a health insurance company, which acts as a "third-party administrator" for the employer's self-funded plan. The best way to find out if your employer-sponsored plan is self-funded is to ask the person who administers the benefits where you work. **Internal appeals to self-funded plans are governed solely by federal ERISA regulations (see below) and individuals may not be able to use their state's external review process.**
- *Insured* employer-sponsored health plan: When an employer purchases health coverage from an insuring organization such as a commercial insurer, a Blue Cross or Blue Shield plan, or an HMO. **Internal appeals to insured health plans are governed by both federal ERISA regulations and state law, as long as the state external review law does not conflict with the federal regulations.**
- ERISA (Employee Retirement Income Security Act): A complicated federal law, which governs the internal appeal process for employer-sponsored health plans and disability insurance programs provided as an employee benefit. For both insured and self-funded employer-sponsored health plans, ERISA regulations establish procedures and timelines for disputes involving claims for treatment coverage. ERISA requires that employer-sponsored health plans let the individual see all documents used by the health in its determination to deny coverage, prohibits more than two levels of internal review, and prohibits the health plan from charging a fee for the review.
- Internal Appeal: The review of denials that are conducted by the health plan. May also be known as grievances or complaints.
- External Review (also called an Independent Review): The reconsideration of a health plan's denial of coverage by an outside, independent organization. In California, external review for most plans is done through the Department of Managed Healthcare or the Department of Insurance.

The Step-by-Step Internal Appeals Process: If you disagree with your health insurance company's decision, the first step is to appeal directly to your health plan. In most states, you must first exhaust your health plan's internal appeals process before requesting an external independent medical review of the insurance company's decision. **If you have an urgent medical condition you can file for an expedited review and file both the internal and external appeals at the same time.**

Step #1: Collect All Relevant Data**:**

- Learn the details of your health plan:
    - Collect information on type of plan, which services your plan covers, whether the plan is self-funded (for employer-sponsored plans), and the internal review processes of the plan. To find this information, read your policy, contract, or Summary Plan Description or speak to the employer's Human Resources representative if it is a group plan.
- Find your plan's coverage language, and figure out why the procedure you are seeking fits into a category of care that the insurer has promised to pay for.

- You have a right to information about why claims are denied. Get the reason in writing from your insurance company.
- If you request it, your insurer must provide the name, title, and credentials of the person who made the decision, the names of experts consulted, the medical review criteria used (or instructions for obtaining this info), contact information and instructions for obtaining additional assistance.
- Start a file for paperwork such as: all medical bills, all "Explanation of Benefits" letters from your health plan.
    - Record notes for every conversation you have with your insurance company. Keep a log of the date of the conversation and the name and contact number of the person you spoke to.
- Gather objective medical evidence to support your appeal that demonstrates why the insurance company should cover your claim. This may include copies of relevant medical records, a letter from your doctor, or even independent research on the treatment or procedure.
    - **Note**: It is not necessary to have this information to appeal, so don't delay a filing if you can't get this information! However, in some cases it can be helpful to have.
- Time limitations: If the insurance company plans to deny all or part of your request for services, they must notify you in writing, within 15 days for prior authorizations or within 72 hours for urgent cases.

Step #2: Try to resolve the issue over the phone:

- Sometimes an insurance company will immediately change their mind if you call customer service. Keep track of who you spoke to and what was said. While requests over the phone are supposed to be logged as complaints that the company must respond to in writing, if your problem is not immediately resolved, the CLRC recommends follow-up in writing to ensure no time is lost in the internal appeals process.

Step #3: Learn the appeals process requirements for your particular insurance company**:**

- Each insurance company has different internal appeals procedures. Most have forms to fill in or download online. If your company does not have a form, the form does not have sufficient space for required information, or you cannot access the form, please refer to the attached letter for a sample internal appeal letter.
- Know the time limits your company has for the internal appeal and file your appeal within the time limits! Failure to observe the time limitations for an internal appeal may result in the loss of the opportunity for an internal *and* external review.
- Your doctor or the insurance coordinator at your doctor's office or hospital may be able to assist you with the appeals process by contacting the insurance company directly on your behalf, or providing advice about what has helped patients in the past who have gone through the appeals process for similar services or treatments.

Step #4: Write an effective appeals letter to your insurance company**:**

- Verbal appeals are often possible, but if you cannot resolve the issue immediately, send the insurance company a letter requesting an appeal, along with supporting evidence if you have any. It is also important to send this letter via certified mail, so that you will be able to track the letter and confirm that your insurance company has received your request for an appeal. Alternatively, you may use their appeal form, but sometimes these are online only and do not allow you to attach additional documentation.
- Time limitations: Federal ERISA regulations require that employer-sponsored health plans (both insured and self-funded) must give the individual at least 180 days after receiving notice that their

claim was denied, to file an appeal. But, be sure to review your specific plan's time limits for each stage of the appeal process.
- In the letter, begin with the following identifying information: your name, policy number, group number, claim number, and clearly state that you are appealing the insurer's denial.
- Also, it is important to include the reason for the denial that they explained in the denial letter; a brief history of the illness and necessary treatment; why you believe the decision was wrong; what you are asking the health plan to do (i.e., approve the requested medical treatment); a request for the insurer's file on the claim.
- Submit additional information, for example, a letter from your doctor, additional medical records, etc, if you have them available.
- Use the CLRC sample insurance letters for assistance.

Step #5: Keep a record of all correspondence and conversations you have with your insurance company**:**

- Be sure to include the dates and times of each contact, the name and title of every person you speak to, make copies of all correspondence, and send all correspondence via certified mail.

Under new regulations established by the Affordable Care Act (i.e. Healthcare Reform), all health plans are now required to provide consumers with information regarding the plan's internal and external appeals processes.

Step #6: Follow up and be persistent:

- Your insurer must make a decision on the appeal within 30 days for prior authorization, within 60 days for medical services already received, within 72 hours in urgent cases. Call your insurance company to ask about the status of the review and keep following up until you receive an official and final response to your request for an appeal, in writing from your insurance company.
- Show your insurance company that you are proactive and persistent, and are willing to pursue the appeal process until you receive a favorable outcome. Some insurance companies intentionally make their appeals process confusing and tedious, so consumers will be deterred from appealing. Simply beginning the internal appeals process will show your insurance company that you will not back down until you receive your medical treatment.

The Step-by-Step External Appeals Process: Your Right to an Independent Opinion

If the insurer does not approve your requested service after you file an internal appeal, you have the right to take your appeal to an independent third-party for review of the insurer's decision. This right to an external review means that the insurance company no longer gets the final say over many benefit decisions. The external review is conducted by an impartial expert who is not a direct employee of or related to your health insurer.

Time limitations: Under California law, you have 6 months to file an appeal with the Department of Managed Health Care or the Department of Insurance. Note that the timeframe will be different for self-insured plans or those in a different state. In these situations you must file a written request for an external appeal within 60 days of the date your health insurer sent you a final decision denying your services or your claim for payment. Some plans may allow you more than 60 days to file your request. The notice sent to you by your health insurer should specify the timeframe in which you must make your request. **If your health issue is urgent, you may file an external review request at the same time you file for an internal appeal**.

Step #1: Determine where to file your external appeal in California:

Type of Insurance	Where to file external review	Contact Information
HMO or Blue Cross/Blue Shield	Department of Managed Health Care (DMHC)	www.hmohelp.ca.gov (888) 466-2219
PPOs and other health plans	California Department of Insurance (DOI)	www.insurance.ca.gov (800) 927-4357
Self-funded Plan	Contracted private independent review board	Check plan policy or internal appeal denial.

Step #2: Request an external appeal in one of the following ways**:**

- For DMHC, fill out an online application at www.hmohelp.ca.gov/dmhc_consumer/pc/pc_imrapp.aspx.
- For DOI, fill out an online application at www.insurance.ca.gov/0100-consumers/0020-health-related/0020-imr/upload/HCB002IMR.pdf.
- For self-funded plans, contact your plan administrator to find the contact information for the Independent Review Organization.
- Check out the CLRC's sample external appeal form and instructions for more information.

Step #3: Your external appeal will be reviewed by an Independent Review Organization:

- The members of the Independent Review Organization must also be individuals who are qualified to conduct the external review based on the nature of the health care service in dispute and must have no conflicts of interest that may influence their decision. The organizations are typically comprised of lawyers, doctors, nurses, or other consultants in that particular area.
- Consumers must be allowed to submit additional evidence in writing to the review organization that must be considered when conducting the external review, and the claimant must be notified of the right to submit additional information to the organization.
- For standard external review, the reviewers must provide written notice to the health plan and the consumer of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request for external review. This decision is binding on both the individual and the health plan. Health plans must also provide an expedited external review process for urgent circumstances and, in such cases, provide notice of the decision no later than 72 hours after receipt of the request for external review.

If you are not satisfied with the result of the external review, you may be able to file a lawsuit in court at this point.

INSTRUCTIONS

The following sample letter is designed for individuals who are appealing an insurance company denial. The purpose of this letter is to provide such a person with an internal appeals request. Please note this sample letter is not intended to be legal advice or a substitute for professional services. It does not establish an attorney-client relationship.

Please read the following before filling out the sample letter.
Replace the sample text in parentheses with your own information.

Either the first or the second paragraph should be included, but not both. The first should be used if you have already received the service or treatment, but the insurance company denied payment. The second should be used if the insurance company has denied a pre-authorization request.

Delete any text that is in *italics* as this is meant to be instruction for you and is not meant to be included in the letter.

[Date]

Customer Service Department

[Health Plan Name]

[Address]

[City, State, Zip Code]

Re: Appeal for [your name]

[Group/Policy Number]

Dear Customer Service Department:

[Paragraph 1] I am writing to seek coverage from [health plan name] for a bill I received for [type of service or procedure]. [Name of provider/doctor] provided this service on [date] for [state reason for treatment – i.e. for treatment of [medical condition]]. I have been billed for [dollar amount of bill], however I believe [health plan name] should cover this procedure. At the time of service, I was covered by your health plan and the care received was a covered service. Included with this letter is a copy of my insurance card with the effective date. *[Attach a photocopy of your card]*

[Paragraph 2] I am writing to seek pre-authorization from [health plan name] for [type of service or procedure]. [Name of provider/doctor] intends to provide this service on [date] for [state reason for treatment – i.e. for treatment of [medical condition]]. [Health plan name] has denied a pre-authorization for this procedure, however I believe it should be covered. I am currently covered by your health plan and this is a covered services. Included with this letter is a copy of my insurance card with the effective date. *[Attach a photocopy of your card]*

On [date] I called [health plan name] and spoke with [name of representative] regarding this issue, but the problem has not yet been resolved.

[If you wish you can include a paragraph with information about why you think the service should be covered, such as it is a covered service under my health plan, I was referred by a primary care physician, the services were/are medically necessary, or the service is a required coverage under state or federal law [cite to specific law]. This information is not necessary for an appeal. Note - if the insurance company denies you, they must provide you the reason for the denial in writing.]

Thank you for your prompt response to this request. As you know, [health plan name] is required to provide me, in writing, with your final answer. Additionally, if it is a denial, you must provide me with the specific reason for denial. If this issue is not adequately resolved through [health plan name], I intend to appeal the decision through the state's external appeal system.

Sincerely,

[Name]

[Address]

Cc: _____ [anyone else you are sending this letter to]

[some possible individuals to send the letter to are your primary care physician, the provider who is billing you, your employer or your medical group, and the health plan.]

Enclosures:

[Copy of bill]

[You can also put in other materials or documentation such as copies of portions of your policy, copy of a letter from your doctor, medical records, or medical journal articles supporting medical necessity of care. However, this documentation is not required for an appeal.]

Below is a sample of a completed letter appealing an insurance company's decision:

January 1, 2012

Customer Service Department

ABC Health Care Insurance Company

100 Main Street

Big City, CA 90000

Re: Jane Smith, PPO, Group 123 / Policy Number ABC456

Dear Mr. Health Care Representative:

I am writing to seek coverage from ABC Health Care Insurance Company for a bill I received for a colonoscopy. Dr. Healthy provided this service on October 26, 2011 as part of my treatment for colon cancer. I have been billed for $2010, however I believe ABC Health Care Insurance Company should cover this procedure. At the time of service, I was covered by your health plan and the care received was a covered service. Included with this letter is a copy of my insurance card with the effective date.

On December 29, 2011 I called ABC Health Care Insurance Company and spoke with Joe Worker regarding this issue, but the problem has not yet been resolved.

Thank you for your prompt response to this request. As you know, ABC Health Care Insurance Company is required to provide me, in writing, with your final answer. Additionally, if it is a denial, you must provide me with the specific reason for denial. If this issue is not adequately resolved through ABC Health Care Insurance Company, I intend to appeal the decision through the state's external appeal system.

Sincerely,

Jane Smith

Cc: Dr. Robert Healthy

Enclosures

INSTRUCTIONS

The following sample is designed for individuals who have exhausted their insurance company's internal appeals system and are seeking an external appeal in California. Please note this sample application is not intended to be legal advice or a substitute for professional services. It does not establish an attorney-client relationship.

External appeals, also called Independent Medical Reviews (IMR), are available in California for those individuals who have exhausted their internal insurance appeals. Note – You do not have to exhaust the internal appeals system if your situation is **urgent**. Individuals with an HMO or any Blue Cross or Blue Shield plan in California can file a request for IMR through the California Department of Managed Healthcare, those with a self-funded plan can request an appeal with the privately contracted company listed on the internal appeals denial, and individuals with other private insurance can file with the California Department of Insurance.

State of California
Health and Human Services Agency
Department of Managed Health Care
INDEPENDENT MEDICAL REVIEW APPLICATION-English
DMHC 20-086 New: 01/02 Rev: 09/12

DEPARTMENT OF Managed Health Care Help Center

INDEPENDENT MEDICAL REVIEW APPLICATION

If you want to give another person the authority to assist you with your IMR, you must also complete the Authorized Assistant Form.

PATIENT INFORMATION

First Name: Jane Middle Initial: Last Name: Smith

Name of Parent or Guardian if Filing for Minor Child:

Street Address: 800 South Figueroa St.

City: Los Angeles State: CA Zip: 90017

Day Phone #: 866-843-2572 Evening Phone #:

Health Plan Name: ABC Health Care Insurance Compa

Patient's Membership Number: ABC456

Patient's Date of Birth (mm/dd/yy): 2/29/1960 Gender: ☐ Male ☑ Female

Do you have Medi-Cal? ☐ Yes ☑ No

Do you have Medicare or Medicare Advantage? ☐ Yes ☑ No

Have you filed a complaint or grievance with your health plan? ☑ Yes ☐ No

Are you seeking payment for a service that you have already received? ☑ Yes ☐ No

YOUR HEALTH PROBLEM

(Use a separate sheet and attach other documents if needed.)

What is your health condition or doctor's diagnosis?

I was diagnosed with colon cancer on September 15, 2011.

What medical treatment or service are you requesting?

I am writing to seek coverage from ABC Health Care Insurance Company for a bill I received for a colonoscopy. Dr. Healthy provided this service on October 26, 2011 as part of my treatment for colon cancer.

How would you like this case to be decided?

I have been billed for $2010, however I believe ABC Health Care Insurance Company should cover this procedure. At the time of service, I was covered by your health plan and the care received was a covered service.

Do you have a condition that is a serious threat to your health? ☐ Yes ☐ No

If "yes," please explain.

Did your health plan say that the treatment you want is (check one):

☑ Not medically necessary ☐ Experimental or investigational ☐ Other

I appealed to ABC Health Care Insurance Company on January 1, 2012. They denied the initial claim, so I appealed again on February 5, 2012. This second appeal was also denied due to lack of medical necessity.

Applications for IMR through the California Department of Managed Health Care (DMHC) can be found at: www.hmohelp.ca.gov/dmhc_consumer/pc/pc_imrapp.aspx

Sample Department of Insurance Application for IMR

STATE OF CALIFORNIA

Dave Jones, Insurance Commissioner

DEPARTMENT OF INSURANCE
HEALTH CLAIMS BUREAU
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov
HCB-002P
Eff: 08/01/2011

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

Name Jane Smith	Work Phone	Home Phone 866-843-2572
Address 800 South Figueroa St.	City Los Angeles	Zip 90017

Please be aware that a copy of this Application for Independent Medical Review will be provided to the insurance company. Also, please be advised that:

- A decision not to participate in the independent review process may cause the forfeiture of any statutory right to pursue legal action against the insurer regarding the disputed health care service.
- Your consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any out-of-plan provider the insured may have consulted on the matter, is necessary to be signed by you.
- You have the right to provide information or documentation, either directly or through your provider, regarding any of the following:
- The provider's recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.
- Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.
- Reasonable information supporting your position that the disputed health care service is or was medically necessary for the medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

1. Complete name of insurance company and policy/certificate number:
   ABC Health Care Insurance Company

2. Claim number and date(s) of medical service(s):
   Claim Number: 01235 - Colonoscopy on October 26, 2011

3. Have you contacted the company to request an Independent Medical Review? Yes ☐ No ☒
   (Provide copies of all correspondence)

4. ☐ If there is an imminent and serious threat to the health of the insured or claimant, please check and indicate the diagnosis. _____

5. Briefly describe the disputed medical service or expense that you want referred to the Independent Medical Review Organization and list the physicians who have treated you for this condition. Use additional paper as needed.
   I am writing to seek coverage for a colonoscopy. Dr. Healthy provided this service on October 26, 2011 as part of my treatment for colon cancer. I have been billed for $2010, however I believe ABC Health Care should cover this.

I hereby request Independent Medical Review of my dispute with the insurer. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the insurer, the California Department of Insurance and any Independent Medical Review Organization. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously release pursuant to this authorization. I attest that the information provided is accurate and truthful

Signature _____ Date _____

Applications for IMR through the California Department of Insurance (DOI) can be found at:
www.hmohelp.ca.gov/dmhc_consumer/pc/pc_imrapp.aspx

Sample Letter Requesting External Review

If an individual has a self-funded plan, they may need to request an external medical review by letter:

March 15, 2012

Customer Service Department
XYZ Independent Medical Reviewers
400 Main Street
Little City, CA 90001

Re: Jane Smith, Request for IMR

Dear Ms. Agent:

I am writing to seek an Independent Medical Review of an insurance denial for colonoscopy coverage from ABC Health Care Insurance Company. Dr. Healthy provided this service on October 26, 2011 as part of my treatment for colon cancer. I have been billed for $2010 (Claim # 01235), however I believe ABC Health Care Insurance Company should cover this procedure. At the time of service, I was covered by your health plan and the care received was a covered service. My ABC Health Care information is: Group 123 / Policy Number ABC456.

I appealed to ABC Health Care Insurance Company on January 1, 2012. They denied the initial claim, so I appealed again on February 5, 2012. This second appeal was also denied due to lack of medical necessity.

Thank you for your prompt response to this request.

Sincerely,

Jane Smith

Cc: Dr. Robert Healthy

Enclosures

INSTRUCTIONS

The following sample letter is designed for California individuals who have an HMO or PPO and have received a 'balance bill' from their provider. Balance billing occurs when an insurance company pays some portion of the bill and the provider bills the patient for the remaining bill. This is illegal under California law – other than billing patients for standard co-pay amounts, the in-network provider is not allowed to bill the patient for the balance of the bill after the insurance company has paid. Out-of-network providers are also not allowed to balance bill in emergency care situations. Please note this sample letter is not intended to be legal advice or a substitute for professional services. It does not establish an attorney-client relationship. For more information about whether balanced billing is allowed in your state, please visit: www.statehealthfacts.org/comparereport.jsp?rep=66&cat=7#notes-1

Please read the following before filling out the sample letter.
Replace the sample text in brackets with your own information.

Delete any text that is in *italics* as this is meant to be instruction for you and is not meant to be included in the letter.

[Date]

[Provider Name or Billing Department]

[Hospital or location of provider]

[Address]

[City, State, Zip Code]

Re: Bill for services provided to [your name]

[Bill number found on bill]

Dear [Healthcare provider]:

On [date], I received a bill from [Provider or department that sent the bill] for services provided on [date of service]. Name of provider/doctor] provided this service on [date] for [state reason for treatment – i.e. for treatment of [medical condition]]. I have been billed for [dollar amount of bill], however I believe this charge should be removed from my bill. My insurance company, [name of insurance company] has already paid for a portion of the services rendered, and this current bill is charging me for the balance. This represents illegal balance billing under California law. I have already paid the co-pay for this service, therefore the remaining balance should not be charged to me. *[or alternatively – I agree to pay the copay of this service, however the remaining balance beyond the copay should not be charged to me*], Any disputes about the amount paid should be addressed directly to my insurance company.

Thank you for your prompt response to this request. If this issue is not adequately resolved in a timely manner, I intend to file a complaint with [*the Department of Managed Healthcare* [for HMOs or all Blue Cross plans] or *the Department of Insurance* [for PPOs]].

Sincerely,

[Name]

[Address]

Cc: _____ [anyone else you are sending this letter to]

[some possible individuals to send the letter to are your primary care physician, the provider who is billing you, your employer or your medical group, and the health plan.]

Enclosures:

[Copy of bill]

Below is a sample of a completed letter appealing an insurance company's decision:

April 1, 2012

Billing Department

XYZ Hospital Facility

100 Main Street

Big City, CA 90000

Re: Bill number: 12345 - Bill for services provided to Jane Smith

Dear Billing Department:

On March 15, 2012 received a bill from XYZ Hospital Facility for services provided on February 5, 2012. Dr. Healthy provided this service for as part of my ongoing cancer treatments. I have been billed for $210, however I believe this charge should be removed from my bill. My insurance company, ABC Insurance Company has already paid for a portion of the services rendered, and this current bill is charging me for the balance. This represents illegal balance billing under California law. I have already paid the co-pay for this service, therefore the remaining balance should not be charged to me. Any disputes about the amount paid should be addressed directly to my insurance company.

Thank you for your prompt response to this request. If this issue is not adequately resolved in a timely manner, I intend to file a complaint with the Department of Managed Healthcare.

Sincerely,

Jane Smith

Cc: Dr. Robert Healthy, ABC Insurance Company

Enclosures