STATE OF NEW YORK
★ ATTORNEY GENERAL ★
EXCELSIOR

Office of the New York State
Attorney General Letitia James

Health Care Helpline

Tips for Faster Complaint Resolution:

Gather Your Documents

Information about how to file an appeal and time limits are available on the Explanation of Benefits (EOB), denial notice, and health plan documents.

Ask Your Provider For Help

They may be able to resubmit your claim, appeal the denial of coverage, provide medical records, or write a letter in support of the appeal.

Document Everything

Keep a copy of everything you send to your insurer or receive from them. Keep written notes of conversations, including the date, the person with whom you spoke, and what was said.

How Does the Helpline Work?

When You Encounter a Health Care Problem with Your Health Care Plan

| Denied coverage for treatment, tests, medical devices, or prescriptions | Improperly charged for "out-of-network" care | Your insurance denied coverage of care for not having "prior authorization" | Improperly billed a balance by an in-network provider |

Your Plan for Complaint Resolution

Call Helpline:
(800) 428-9071

OR

File Online Complaint:
ag.ny.gov/insurance-complaint

Helpline Intake Specialist
Receives complaint

Assign Advocate

Refer to Correct Agency

Advocate Attempts Resolution
Speaks with you, reviews your documents, and contacts your health plan or provider if needed

My health insurance plan denied a claim, what can I do?

You have a right to know why a claim was denied and to appeal that decision. Ask your health insurer to review its decision through the internal appeal process, which often includes two levels of appeal.

Why was I denied coverage by my health insurance plan?

Review your Explanation of Benefits (EOB), or your notice of denial. The EOB is a statement sent by your health insurance company explaining what it will cover and any costs you may have to pay out of pocket. It is sent after your doctor submits a claim. You may also call your health plan for an explanation.

When must I appeal?

Plans have different time limits and rules for appealing. **ACT QUICKLY.**

My insurer sent me a denial letter, what else can I do?

If your internal appeal fails, you may have other options depending on your type of health plan and the type of denial. You may have the right to make an external appeal to the NYS Department of Financial Services for an independent review by a medical professional.

YOU CAN GENERALLY CHALLENGE THE FOLLOWING:

PROBLEM:	WHAT TO DO:
No Prior Authorization: Your health insurance plan requires your doctor to get approval for certain medicines, tests, medical devices, or procedures before it will pay for the cost.	Ask your doctor to request prior authorization, showing the care or medication you are seeking is medically necessary or that you meet the requirements for approval.
Not a Covered Benefit: A medication, test, procedure, or specific care isn't covered by your plan.	Double-check your benefits in your member handbook and push for coverage where exclusions are vaguely worded or the plan documents could be interpreted to provide coverage for the denied service.
Not Medically Necessary or Investigational/Experimental: Insurance plan will not pay for the care you are seeking because they find it not "medically necessary" or it doesn't meet the accepted standards of good medical practice for treating your condition or disease.	Work with your doctor to obtain documents and other proof to explain to the plan that your treatment is medically necessary.
"Out-of-Network": You are denied a coverage of treatment by a specialist or other provider outside of your plan's network of doctors.	Check your provider directory; if the doctor was mistakenly included, contact your insurer. If you were treated in the emergency room by an out-of network doctor or your primary physician referred you to a doctor who you did not know was out-of-network, New York law protects you. Contact your insurer.