



Insurance Issues

Updated 12/21/2008

**Please check back for additions and future revisions as information changes constantly and we will attempt to incorporate new information as frequently as possible.

IMPORTANT: This document is intended to be a guide for people looking for help when insurance denies care for treatment of eating disorders. The authors are parents and professionals who have had experience fighting for care. We are not attorneys, we are not giving legal advice, and we do not intend this as a legal document. While we believe that the information contained in this document will be helpful, we cannot guarantee that you will be successful in getting your insurance company to pay for care.

I. INTRODUCTION

The National Eating Disorders Association (NEDA) fields thousands of questions each day. Many of them focus on how to gain access to care and navigate insurance issues. While there is little argument that early intervention offers the best chance for recovery, insurance often works as a barrier to prompt, thorough treatment. Eating disorders are life-threatening illnesses and anorexia has the highest mortality rate of any mental illness, yet insurance companies routinely deny coverage for treatment even though studies have shown that a full course of treatment is cost effective (Halmi et al 2000; Halmi and Licino 1989; Baron et al 1995 & Garfinkel 1995; Reas et al 2000).

NEDA has asked a group of family members and professionals from across the United States who have experienced fighting insurance companies to develop a guide for people looking for help. We have put our ideas and strategies together and we encourage you to use any or all of the suggestions in your quest for care. Please let us know if the information has been helpful or if you have suggestions, feedback or personal additions that you could make to this document (e.g. submit a sample letter to your insurance company with all identifying information removed) by emailing info@nationaleatingdisorders.org with "Insurance Issues" in the subject line.

II. THE PROBLEM

Here are some stories that illustrate the problem:

Anna Westin was struggling with anorexia and needed intensive, specialized care. Her insurance company repeatedly denied this care stating that her treatment was "not medically necessary." Anna died from anorexia on February 17, 2000. Her parents, in coordination with the Minnesota Attorney General, sued the insurance company. The suit was settled out of court and the result has been greatly improved access to care for people with eating disorders and all mental health diagnoses in Minnesota. (For more information, go to the Anna Westin Foundation website at: www.annawestinfoundation.org.)

Jane Doe* was diagnosed clinically anorexic by her therapist and recommended for inpatient treatment. Jane's insurance company repeatedly denied the inpatient treatment facility that Jane selected, stating that Jane needed to be treated by an "in-network" facility in her state. The problem was that none of the recommended insurance facilities treated eating disorders. The state also did not have an inpatient eating disorders treatment facility. After several denied appeals, Jane's insurance company did pay for 36 days of inpatient treatment, which was stated in her summary of benefits under the mental health section. The



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reimbursement was for about 50% of the total inpatient cost. Persistence and the help of the appeal process by the treatment facility *did* pay off. (*Name changed for confidentiality.)

Shelby Starner was hospitalized for medical stabilization after a blood test proved bulimia put her at risk of a heart attack due to low potassium and electrolytes. She was 17 and had been treated for five months, while her weight loss continued with brief weight stability. The hospital administered IV stabilization, but no psychological, psychiatric or nutrition therapy, even though without those support therapies the benefit of medical stabilization via IV would be short lived. The family discovered that this hospitalization and a psychiatric evaluation might afford Shelby access to an inpatient eating disorders treatment facility. After demanding and getting a psychiatric evaluation from the hospital, Shelby was discharged and went to the treatment center for further evaluation. Although about 30 pounds below her normal weight, it seemed that the insurance weight/height charts did not prove Shelby sick enough for inpatient treatment. She added weekly outpatient group therapy (90 miles from home) to her 1-3 times a week private psychological visits, daily medication, and visits to the family doctor and dietician, little of which was covered by insurance. The stress, travel and cost of group seemed to be doing more harm than good, and Shelby gave up the long distance therapy after a few months. She reasoned that, if she was really sick, they would have admitted her to inpatient treatment. Although their concern continued, now that Shelby was 18, the family was marginalized from her care. Shelby struggled for a total of 26 months until she died at home. An autopsy found that brain swelling due to an electrolyte imbalance—a direct result of bulimia—caused an event that probably killed Shelby instantaneously. Her family believes that Shelby was the victim of care based on the insurance company protecting their bottom line, rather than care based on patient need.

These stories are all too familiar and we believe that denying care to critically ill individuals is discriminatory, illegal, and immoral. Families often find that insurance companies are more interested in short-term costs. Unfortunately, insurance companies make it very difficult for people to get the treatment necessary to fight an eating disorder, often citing a lack of “standards” of care. However, there are accepted standards of care. The American Psychiatric Association (APA) has published standards of medical care for eating disorders that clearly describe criteria for treatment and admission for medical reasons (see link under section III, number 2). Many insurance companies ignore these standards and use their own criteria that have no medical rationale and are not set by medical professionals. In addition, most insurance companies are unwilling to give families a copy of the criteria they use, making it extremely difficult to understand how they decide what level of care your loved one needs. We understand that people who are desperately seeking care for someone they love have little time or energy to fight their insurance company. It is extremely frustrating when your insurance company questions the professional’s advice. We hope that following these recommendations will make your undertaking easier and secure a successful outcome.

III. RECOMMENDATIONS FOR FAMILIES

A. EDUCATE YOURSELF

The first step towards getting what you or your loved one needs is to educate yourself. If you have not already read the “Eating Disorders Survival Guide.” Be sure to start there before proceeding with this document.”

http://www.nationaleatingdisorders.org/uploads/file/information-resources/Eating%20Disorders%20Survival%20Guide%20revised%2012_21_2008.pdf

1.) DETERMINE WHAT TYPE OF BENEFITS YOU HAVE

Read your insurance manual, learn everything about your policy (including billing processes, appeals process and rules in your state) and determine if you have mental health benefits and what those benefits are. Keep in mind that your benefits may be more flexible than you think or that your insurance company lets on. For example, in one plan, 30 hospital days equaled 60 residential days, which equaled 120 treatment services. Also keep in mind that the insurance person you speak to may not even know this or may not be encouraged to share this information unless you ask the “right” questions.



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In addition, find out which covered treatments are funded through the health section of your plan and which are funded through mental health services. Try to keep medical services funded through the medical section of your plan. For example, if the psychiatrist is providing medication management services, utilize your medical coverage because there is often lower co-pay and services are not as limited.

If you have difficulty understanding your benefits call the number on the back of your card and talk with a customer service representative or call your insurance agent. **Important:** Don't accept an explanation of benefits from just anyone; ask to speak to the "manager of benefits" because you need to have accurate information as you move forward. At this time request an individual case manager so you have a specific name and contact information to use when you have questions/concerns. **Record everything** that you are told including the date and time of the call. It may also be helpful to contact the personnel department within your company if applicable. Your company and you are purchasing a "product" from the insurance company. Your employer has the power to "fire" the insurance company if it does not provide adequate service and your company can pressure the insurance company to provide the best possible service to its customers.

We also recommend that you find out if your state has a Mental Health Parity Law. Mental health parity simply means that your insurance company must not limit mental health and substance abuse healthcare by imposing lower day and visit limits, higher co-payments and deductibles, and lower annual and lifetime spending caps than those for health care. For more go to the National Mental Health Association's website, <http://www.nmha.org/go/parity/states> for a complete list of which states have parity, which are the "best" and "worst," and which states have no parity laws in effect.

We also urge you to join in the effort to influence federal policy at : <http://www.eatingdisorderscoalition.org/>

2.) REVIEW LEVEL OF CARE GUIDELINES

American Psychiatric Association (APA): <http://www.psychiatryonline.com/popup.aspx?aID=139471>

American Academy of Pediatrics : <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/1/204#SEC6>
or printable pdf version at: <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;111/1/204.pdf>

Society for Adolescent Medicine : http://www.adolescenthealth.org/PositionPaper_Eating_Disorders_in_Adolescents.pdf

Note that the newest guidelines supersede any previous guidelines even if you are trying to get coverage or payment for treatment that originally fell under the old guidelines. Be sure you are using the most current guidelines (or policy statement) available.

Request and review the guidelines your insurance company uses. Note: they may be resistant to giving you these but you have a right to see them and they *must* provide them to you.

(See sample letter #1)

3.) REVIEW YOUR CHILD'S NEEDS

Meet with the treatment team to establish your child's current treatment issues and to determine the appropriate level of care based on the above practice guidelines.

Have at your disposal the current guidelines that are appropriate for your child (see above for links) and share a copy with your insurance company and the treatment team. Request that your child's current level of care be based on the accepted guidelines and if the request is denied insist that your insurance company take full responsibility **(IN WRITING)** for your child's life, noting that they are disagreeing with the qualified experts in the field and the approved guidelines.



Keep in mind that a more intensive level of care might be necessary due to distance between your home and the services available. Remember: **YOUR CHILD DOES NOT NEED TO “FAIL” AT A LOWER LEVEL OF CARE TO RECEIVE THE APPROPRIATE LEVEL OF CARE!**

B. CONTACTING THE INSURANCE COMPANY FOR SERVICES

Once you understand your insurance, it is time to contact your insurance company. You may want to consider contacting an attorney at this point for consultation as roadblocks appear. **From this point on it is imperative that you document everything. Keep written records of all communications with your insurance company, keep all explanations of benefits you receive, and write everything down along with the name of the person you spoke to, the time and date, what was discussed, and any advice or decisions that were made.** It is a good idea to do this from the very beginning, but it is especially crucial from here on out.

Things to remember:

- Thank and compliment when possible. You're more likely to receive friendly service if you are nice too.
- Keep records of all communications.
- Send important letters that you want noticed or responded to via certified mail to ensure they can be tracked and signed for at the recipient location.
- Make follow-up phone calls to your requests so you are not forgotten.
- Don't assume one department knows what the others are doing. Inform all the departments including health, mental health, enrollment, etc.
- Don't panic initially. It is possible that a denial can be an automatic computer generated response that requires a "human override." Follow-up!
- Remember: your insurance company only knows what you and the treating professionals tell them. Make sure they have all information necessary to make decisions that will be of most benefit to you or your loved one.
- Take nothing for granted. Go into this with your eyes wide open. They are not the enemy – only uninformed. Treat them as people who have a rough job to do.

HERE WE GO!

- 1.) Ask that a case worker be assigned to you. This service is seldom offered but should be available and is valuable for any long-term illness. You can establish one person to contact, which will save you the frustration of repeating your story every time you make a call to your insurer. That one individual is more likely to feel a sense of responsibility for your or your loved one's care and you will be positioned to ask, "Are you willing to take responsibility for denying the care that my doctor has recommended?"
- 2.) Ask for a list of professionals (qualified experts) and facilities utilized by your insurance company for this illness at this level of care.
- 3.) Ask for a copy of the guidelines your insurance company uses to determine level of care.
- 4.) Start a notebook and keep records of all communications, letters and phone calls.
- 5.) Share a copy of the guidelines you have utilized with your treatment team to make recommendations to your insurance company.
- 6.) Review your child's current level of needs based on these guidelines with your insurance company. At this point submit documentation requesting service.

(See sample letter #2)



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Remember: you are not asking for anything you are not entitled to – you have paid for health care and you should expect to get what you pay for when you or someone in your family becomes ill. Eating disorders are both medical and psychological illnesses. Don't be afraid to point this out to your insurance company and site research if necessary to back up your argument (See "Securing Eating Disorders Treatment: Ammunition for Arguments with Third Parties" by Margo Maine, PhD, on the NEDA website <http://www.nationaleatingdisorders.org/nedaDir/files/documents/handouts/SecrTxAm.pdf>).

7.) In retrospect: If your child is already in a program or facility ask the insurance company where to send her/him that is equal in quality and standards. Usually by this time your child will have established a rapport with the team and it would be upsetting and detrimental to treatment if moved. There is the chance that your insurance company will keep your child where you have placed her if you present your case and supply supporting documentation of your child's treatment plan.

(See sample letter #3)

8.) Complications: Less than full-time student status. If you need to address the issue of your child's status as a less than full-time student due to her medical issues the following letters might be helpful.

(See sample letters #4 & 5)

C: WHAT TO DO IF/WHEN TREATMENT IS DENIED

After you receive the first denial of services you can begin the appeals process. If you have not already done so, you may want to contact an attorney at this point so you have guidance as roadblocks appear.

Important reminder: Document Everything! It is better to err on the side of too much documentation than not enough.

1.) Learn the "rules."

One of the first things you will need to find out is what the "rules" are for filing appeals with your insurance company. This may be harder to come by than you think as insurance companies generally have access to their rules and you don't. Call the company and ask for a detailed description of the appeals process and who makes the decisions within the company. You may be told that some or all of this information is unavailable but *insist* that they release it to you. We have found that it is a standard practice in some companies to hide from subscribers the true conditions, standards and criteria for denials of coverage, which places the subscriber at an unfair disadvantage during the appeals process. Also, request the name of the President/CEO of the company and all board members. It's advised that you send copies of all letters, forms, requests, etc. to the president of the company and the members of the Board of Directors. Keep in mind that many of these people are parents too and wouldn't want to have their daughters/sons in a position where they couldn't receive help.

2.) Start the process.

Once you have the correct information you can start the appeals process. Submit all forms and be certain that you are very careful as you fill the forms out. We discovered that most companies insist that you follow the process **exactly** and making even simple and insignificant mistakes like misspelling a word or using the wrong color ink can cause long delays. Once you submit the first appeals form, be prepared to get a letter stating that the appeal was denied. Many people simply give up at this point thinking that they have exhausted the process. **This is not true.** Most companies have several levels of appeals and after those are exhausted most states have a process as well. Your state and federal representatives can be helpful at this point in the process. (Return to the "Eating Disorders Survival Guide" for web links to your representatives).

It is important to note that very often insurance companies deny or limit coverage after mere "paper reviews," contradicting the judgment and recommendations of the professionals who have examined and/or treated you or your



family member. This is unacceptable and with the proper documentation you should be able to state your case very clearly.

3.) Submit documentation.

The next step is to write a clear, concise cover letter that is brief, states your expectations and goals and also sets a timeline for a resolution of the issue.

4.) The “Ask.”

Remember to be clear about what you are asking for – if residential treatment is indicated that is what you must ask for. Collect data that will corroborate your request by asking your doctor, psychologist, dietician, and other treatment professionals to write letters of support with their arguments for the level of care they are recommending. (See sample letter #6 that your physician can use as a template.) Include medical test results, facts, research and any other information that states your case. It may be helpful to include a copy of the APA Guidelines for eating disorders treatment, which are the recognized standard of care among professionals.

Important note: Stress the need for a **QUALIFIED EXPERT** not a specific provider. The discussion must be about appropriate care *not* “best care in the world.” This is very important! Your insurance company is much more likely to assist you if you make a reasonable case. Frequently they are not looking for a struggle but do not have the time or expertise to support what you are requesting.

Send all of the information you gather to your insurance company’s customer representative and review board. Also copy the president of the company, members of the board of directors, your state’s Attorney General, Insurance Commissioner, governor, Federal and State Congress Members, advocacy organizations, your attorney and anyone else who may be able to intervene on your behalf. The “Eating Disorders Survival Guide” has links to these contacts.

4.) Go Public.

If you are ready to go public with your story, you may want to take your story to the media. This is an important decision and should be carefully considered. Media attention can be overwhelming and it exposes the person and family, resulting in a loss of privacy. Take time to discuss the consequences of a decision to go to the media with the entire family before proceeding. If you choose to contact the media NEDA has helpful handouts including, “Tips for Responsible Media Coverage” and “Guidelines for Sharing Stories of Recovery.” Find both at the following link:

<http://www.nationaleatingdisorders.org/in-the-news/press-room.php>

D. DON’T GIVE UP!

If your request is still denied, request **IN WRITING** that the insurance company takes full responsibility for your child’s life noting that they are disagreeing with the qualified experts in the field and the accepted guidelines.

(See sample letter #7)

Most insurance companies count on people giving up and accepting their ruling after the first or second denial. **DO NOT GIVE UP!** It is highly likely you will succeed if you follow through with the entire appeals process. The vast majority of people who appeal denials by insurance companies are able to reverse the decision and are granted at least part of what they are requesting.

Do not accept your insurance company’s position on levels of care, length of stay and providers. Take responsibility for finding appropriate treatment and make sure you or your loved one see an eating disorders professional. Be assertive and don’t be afraid to fight for what is “right and just.” Do not be intimidated by the tactics of your insurance company. They will put up roadblocks but there are ways around them. **Be persistent** and continue to ask for what you need.



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Additional information that may be helpful in your process is available in Dr. Ed Tyson's new patient info: http://www.drtyson.net/images/new_patient_forms.pdf . On pages 18-21, you will find "Recommendations for improving insurance reimbursement" and pages 16-17 provide insurance info as it applies to his practice. In addition, there is some information in the bimonthly article and archives at http://www.drtyson.net/bimonthly_article.html .

E. TAKE CARE OF YOU!

REMEMBER, you can't help your child if you also become ill or less functional. Depending upon how you and your family are doing, you might want to consider one OR all of the following:

Seek help from an individual or family counselor for yourself, you and your spouse, a sibling, and/or the entire family.

Take time for yourself, your marriage or partnership (e.g. go out on a date!), or take time individually with one of your other children that needs attention. You may not think you have time for this but it will keep you all well, functional, and energized. This will SAVE TIME in the long run!

Seek support from family, friends, and/or professionals that you feel can be helpful. Keep in mind that when family and friends offer to help, it's because they want to – so let them be supportive by helping you and your loved one.



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IV. SAMPLE LETTERS

This section provides sample letters that were referenced throughout the document. It is suggested that when writing letters that you thank people when possible, compliment things that have been helpful, and provide specific information for your request or solution you are suggesting.

- Note:
- * Follow up letters with phone calls and document who you speak to.
 - * Don't assume one insurance department knows what the other is doing.
 - * Don't panic! Your current issue or rejection can be a computer generated "glitch."
 - * Copy letters to others relevant to the request.
 - * Supply supporting documents.
 - * Get a signed delivery receipt – especially when time is of the essence.

SAMPLE LETTER #1:

This sample letter is a request that co-pay for the patient's psychiatrist be changed to a medical co-pay (\$20.00) instead of a mental health co-pay (\$50.00 which, of course, is a parity issue and also needs to be addressed but not in this context!) since the psychiatrist was providing medication management and NOT psychotherapy.

Outcome: Adjustments were made and the family was billed for the medical co-pay. Remember, the psychiatrist *must* use the proper billing code!

DATE

To: Clinical Appeals Specialist
INS. CO. NAME & ADDRESS

From: YOUR NAME & ADDRESS

Re: PATIENT'S NAME
DOB (Date of Birth)
ID#

Dear Mr./Ms. Clinical Appeals Specialist NAME:

First, I would like to thank you for assisting me with my daughter's medical care. This process is very draining on the entire family. However, the cooperation of the fine staff at INSURANCE COMPANY NAME makes it a little easier.

At this time, I would like to request that INS. CO. review the category that Dr. NAME's services have been placed into. It appears that I am being charged a co-pay for his treatment as a mental health service when in reality he provides PATIENT NAME with pharmacological management for her neuro-bio-chemical disorder. Obviously, this is purely a medical consultation. Please review this issue and kindly make adjustments to past and future consultations.

Thank you, in advance, for your cooperation and assistance.

Sincerely,

YOUR NAME



SAMPLE LETTER #2:

This letter addresses the need for flexing hospital days for counseling sessions. In this case, the family needed to document patient's level of need versus her outpatient status to make this happen. Remember, just because you are utilizing outpatient services does not mean that you cannot take advantage of benefits matching a more acute level of care if your child is eligible for that level of care. The insurance company only knows the information you supply so be specific and provide support from the treatment team!

Outcome: 10 Hospital days were converted to 40 counseling sessions.

DATE

To: Ins. Co. Management Dept
INS. CO. NAME & ADDRESS

From: YOUR NAME & ADDRESS

Re: PATIENT'S NAME
DOB (Date of Birth)
ID#
Case #

To whom it may concern:

This letter is in response to your denial of continued counseling sessions for my daughter. I would like this decision to be reconsidered based on the fact that PATIENT NAME continues to meet the American Psychiatric Association's guidelines for Residential treatment/Partial hospitalization. Her primary care provider, NAME, supports her need for this level of care (see attached – Sample Letter #3 below provides an example of a physician letter). Therefore, although she chooses to receive services with an outpatient team and a great deal of support from her family, she requires an intensive level of support from her team, including ongoing counseling, to minimally meet her needs. I request that you correct the records re: PATIENT NAME's level of care to reflect her needs and support these needs with continued counseling services since Partial hospitalization/residential treatment is a benefit she is eligible for and requires.

I am enclosing a copy of the APA guidelines and have noted PATIENT NAME'S current status. If you have further questions you may contact me at: PHONE# or Dr. NAME at: PHONE#.

Thank you in advance for your cooperation and prompt attention to this matter.

Sincerely,

NAME

Cc: Case manager
Ins. Co. Medical manager



SAMPLE LETTER #3:

This letter is a correspondence with an HMO seeking reimbursement for services rendered when there was not enough time to pre-authorize due to the nature of this illness and the need to deal with it in a timely/urgent manner. Acting on friend and the daughter's OB/ GYN recommendations, the family had to "act fast, hit it hard or move to a third world nation!" So they chose to act fast and went with the qualified expert's recommendations based on the APA guidelines. Remember: you need to research the professionals available through your plan and local support systems. In this case, after contacting their local association for eating disorders experts, they realized that there were no qualified medical experts in their area to diagnose and make recommendations for their child. Keep in mind that you need to seek a qualified expert not a world famous expert and make sure you provide very specific information for your research.

Outcome: Reimbursement was provided for the evaluating/treating psychiatrist visits and medications. Further research and documentation was required to seek reimbursement for the treatment facility portion.

DATE

To: INS. CO. NAME & ADDRESS

From: YOUR NAME & ADDRESS

Re: PATIENT'S NAME

DOB (Date of Birth)

ID#

Case #

To whom it may concern:

Since earlier this year my daughter has been treated for an eating disorder. She was first seen at the college health clinic at (UNIVERSITY NAME) and then referred for counseling which was arranged through (INS. CO.). At the end of the semester I met with (PATIENT NAME) and her therapist to make plans for her summer treatment. At that time, it was mentioned that (PATIENT NAME) might need residential placement, which obviously became a serious concern for my husband and me. Of course we sought the opinion of a qualified expert regarding this serious matter. I first spoke to PATIENT NAME'S PCP and then contacted the local eating disorders support group. No qualified expert emerged quickly from the community of our (INS. CO.) network providers. In doing my own research, it became apparent that Dr. NAME at HOSPITAL in LOCATION was the appropriate person to contact to expedite plans for our daughter. Dr. NAME was willing to see her immediately and we made those arrangements. As you can imagine, this was all very stressful for the entire family. Since time was so important we went ahead with the process and lost sight of the pre-approval needed from (INS. CO.). I am enclosing the bills we paid for those initial visits for reimbursement. PATIENT NAME was consequently placed in a residential setting in the LOCATION area and continues to see Dr. NAME through arrangements made by (INS. CO.).

In addition, at the beginning of her placement there was some confusion about medications necessary for PATIENT NAME during this difficult/acute care period. At one point payment for one of her medications was denied even though it was what the team treating her was recommending and prescribed by her primary care physician, Dr. NAME. I spoke to a (INS. CO.) employee named (insert name) at PHONE # to rectify the situation and I believe she did, however it was a little too late to meet my timeframe for visiting PATIENT NAME so I paid for the Rx myself and expect reimbursement at this time. If you have any questions please speak to (employee name).

Thank you in advance for your cooperation. If you need any further information you may contact me at: PHONE.

Sincerely,
NAME



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SAMPLE LETTERS #4 & #5:

The two following letters were written to address the fact that our daughter would be attending college in a less than full-time capacity at a local university and would remain at home for a semester due her illness . When she did not register at her primary university for the fall semester she was automatically terminated from our insurance policy beginning June 1st of that prior summer. As you can imagine, this automatic termination could have caused an enormous amount of paperwork for all involved if it was not rectified IMMEDIATELY. The first letter was to inform our insurance company of our daughter's current enrollment status in what we considered a timely fashion, and the second letter is in response to her abrupt and retroactive termination. In reality, she was eligible for a medical leave of absence from college for up to one year.

Outcome: Luckily our daughter was immediately reinstated as a less than full-time student. Afterwards we found out that she could have requested a one-year medical leave of absence.

DATE

To: NAME OF CONTACT PERSON IF KNOWN
INS. CO. NAME & ADDRESS

From: YOUR NAME & ADDRESS

Re: PATIENT'S NAME
DOB (Date of Birth)
ID#
Case #

Dear NAME,

We spoke the other day regarding my daughter's enrollment status. I am currently following your instructions and you should receive a letter from Dr. NAME shortly regarding PATIENT NAME's medical status requiring her to reduce the number of classes she will be able to take this fall. When she completes her re-enrollment at UNIVERSITY NAME (which she can't do until the first day of classes, DATE), she will have the registrar's office notify you of her status.

At this time, NAME plans to be a part-time student at UNIVERSITY for the DATE semester and hopes to return to UNIVERSITY in DATE. If all goes well she may be able to graduate with her class and complete her coursework by the DATE in spite of her medical issues. If you have questions regarding these plans you may want to speak with PATIENT NAME'S school advisor Mr./Ms. NAME whom PATIENT NAME has released to speak to you. She has been assisting PATIENT NAME with her academic plans and is aware of her current medical status. Her phone number is: PHONE #.

Please feel free to contact me at PHONE # if you have any questions or need any further information. Thank you for your assistance.

Sincerely,

YOUR NAME



SAMPLE LETTER #5 cont.:

This second letter was written because although we'd been in contact with the enrollment department regarding my daughter's academic status, her coverage was terminated retroactively to June 1st by the computer.

(HEADING SAME AS IN PREVIOUS LETTER)

Dear NAME:

It is with shock and disbelief that I read the attached letter (Send a copy of the letter you received) that you sent to my daughter to notify her of termination of coverage. PATIENT NAME has been receiving extensive treatment through INSURANCE COMPANY NAME for serious medical issues since DATE. We have received wonderful assistance from NAME, Case Manager (PHONE#); NAME, Mental Health Clinical Director (PHONE#); and Dr. NAME, INS. CO. Medical Director (PHONE #) throughout PATIENT NAME'S treatment.

I am writing to you to describe the timeline of events and am copying this letter to the people that have assisted us as noted above.

In DATE PATIENT NAME requested a temporary leave of absence from UNIVERSITY 1 NAME to study at UNIVERSITY 2 NAME for one year. She was accepted at UNIVERSITY 2 NAME and attended the DATE semester. At the end of the DATE semester PATIENT NAME'S medical issues intensified and PATIENT NAME returned home for the summer. Suffice it to say that the summer of YEAR has been very complicated and a drain on our entire family. The supportive people noted earlier in this letter made our plight bearable but we were constantly dealing with one medical issue after another.

At the beginning of DATE, PATIENT NAME and her treatment team members began to discuss PATIENT NAME'S needs for the DATE semester of YEAR. As far as our family was concerned, since we do not have a crystal ball to predict the future nor did we change her plans as a visiting UNIV. 2 student, all options (UNIV. 1, UNIV. 2, & several local options full and part-time) were still up for discussion. We hoped that with the help of her medical team we could make appropriate plans for PATIENT NAME in a timely fashion.

During PATIENT NAME'S appointments the first two weeks of August it became clear that the treatment team agreed that PATIENT NAME should continue to live at home and attend a local university on a part-time basis for the fall semester. This decision was VERY difficult for PATIENT NAME and our family. PATIENT NAME still hopes/plans to return to UNIV. 1 in January as a full-time student. She has worked with her UNIV. 1 advisor since August 9th to work out a plan that might still allow her to graduate with her class even if she needed to complete a class or two in the summer of YEAR. This decision by NAME was difficult but also a major breakthrough/necessity for her treatment.

After the plans were decided I called the enrollment department at INS. CO. NAME to gain information about the process of notification re: this change in academic status due to her current medical needs. I was told by NAME that I needed to have her primary care physician write a letter supporting these plans, which is being done as we speak, and as soon as PATIENT NAME'S fall classes are finalized on August 30th that information will also be sent to you. So, as I hope you can see, PATIENT NAME was to be a full-time student this fall until her treatment team suggested otherwise in the early part of August. At that time I began the notification process. Please assist us in expediting this process. I ask that you immediately reinstate her as a policy member. If her status is not resolved immediately it will generate a GREAT DEAL of unnecessary extra work for all parties involved and, quite frankly, I'm not sure that our family can tolerate the useless labor when our energy is so depleted and needed for the medical/life issues at hand.

I am attaching 1.) my previous enrollment notification note, 2.) PATIENT NAME'S acceptance from UNIV. 2, 3) a copy of PATIENT NAME'S apartment lease for the year, and 4.) her recent letter to UNIV. 2 notifying them that she will be unable to complete her year as a visiting student for medical reasons.



Please call me TODAY at PHONE # to update me on this issue. This is **very** draining on our family. If people that have been working with NAME all summer are notified that she has been terminated as of DATE it will become a NIGHTMARE FOR ALL OF US ... doing, undoing, and redoing all of the paperwork! Thank you for your assistance. Please call A.S.A.P.

Sincerely,

YOUR NAME

Cc: CASE MANAGER
MENTAL HEALTH CLINICAL DIRECTOR
MEDICAL DIRECTOR



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SAMPLE LETTER #6

It may be helpful for your child's medical doctor to write a letter describing any medical complications that your child has had, recommendations for treatment and predictions of his/her outcome if this treatment is not received. This is a sample physician letter that parents can bring to their child's doctor as a template to work from.

DATE

To: Ins. Co.
INS. CO. NAME & ADDRESS

Re: PATIENT'S NAME
DOB (Date of Birth)

To Whom It May Concern:

We are writing this letter to summarize our treatment recommendations for Jane Smith.

We have been following Jane in our eating disorders program since DATE. During these past NUMBER years, Jane has had NUMBER hospitalizations for medical complications of her malnutrition including profound bradycardia, hypothermia and orthostasis.

Her hospital admissions are listed below:

Admission Date – Discharge Date Profound bradycardia
Admission Date – Discharge Date Profound bradycardia and hypothermia
Admission Date – Discharge Date Bradycardia and orthostasis
Admission Date – Discharge Date Bradycardia
Admission Date – Discharge Date Orthostasis
Admission Date – Discharge Date Bradycardia

In all, Jane has spent NUMBER days of the past NUMBER years in the hospital due to cardiac complications of her malnutrition.

Jane's malnutrition is damaging more than her heart. Her course has been complicated by the following medical issues:

1. Secondary amenorrhea since DATE. This prolonged amenorrhea has the potential to cause irreversible bone damage leading to osteoporosis in her early adult life.
2. As above, significant risk for osteopenia. Bone density results are pending examination.
3. Essential fatty acid deficiency, which can impact all organs, most especially her neurocognitive function.
4. Hypophosphatemia
5. Constipation, delayed gastric transit, and abdominal pain
6. Leukopenia
7. Hypoalbuminemia

Despite receiving intensive outpatient medical, nutritional and psychiatric treatment, Jane's medical condition has continued to deteriorate. She has had consistent weight loss since DATE and is currently 83% of her estimated minimal ideal body weight (the weight where the nutritionist estimates she will regain regular menses). Her white blood cell count and serum protein and albumin levels have been steadily decreasing as well, because of her extraordinarily poor nutritional intake.

Due to Jane's poor nutritional progress and continued medical complications despite receiving intensive outpatient treatment for anorexia nervosa, it is our strong recommendation that she needs more intensive psychiatric and nutritional treatment. The type of treatment that Jane needs is offered only in a residential treatment program specializing in eating



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disorders. We recommend a minimum of a 60-90 day stay in a program that offers a tiered approach, with intensive residential and transitional components that focus on the care of adolescents and young adults with eating disorders. Jane requires intensive daily psychiatric, psychological and nutritional treatment by therapists well trained in the treatment of her disease. She will be best served by a program that is age appropriate for her and not a program for much older adults. In such a tiered program, Jane could get the residential treatment that she so desperately needs and then show that she can maintain any progress in a transitioned setting. We do not recommend treatment in a non-eating disorder specific behavioral treatment center as Jane has a severe case of anorexia and deserves subspecialty-level care. Some examples of such programs would include (name a few appropriate programs).

Anorexia nervosa is a deadly disease with a 10-15% mortality rate and 15-25% developing a severe lifelong course. We believe that without the intensive treatment of a residential program, Jane's malnutrition, and the medical complications that it causes, will continue to worsen and Jane will be at significant risk of developing lifelong anorexia nervosa or dying of her disease. We understand that in the past, your reviewers have denied Jane this level of care.

This is the only appropriate and medically responsible care plan that we can recommend for Jane. We truly believe that to offer her less is medically negligent, and trust that you will share our grave concern for Jane's needs and approve such care to assist in her emotional and physical recovery.

Thank you for your thorough consideration of this matter. Please feel free to contact us with any concerns regarding Jane's care.

Sincerely,

Physician Name



SAMPLE LETTER #7:

Our next “discussion” with the insurance company was re: residential placement. Basically the HMO (represented by Value Options) suggested that our daughter needed to fail at less restrictive treatments before she could be eligible for a residential setting. In a telephone conversation I asked Value Options to place a note in her records saying that I request that they put in writing that they are disregarding the APA guidelines and the recommendations of her treatment team and that they (Value Options and our HMO) would now be responsible for my daughter’s life. (SEND BY CERTIFIED MAIL!)

Out come: Very shortly I received a letter authorizing the residential placement.

The following is an example of how you might put this in writing:

DATE

To: Ins. Co. Management Dept
INS. CO. NAME & ADDRESS

From: YOUR NAME & ADDRESS

Re: PATIENT’S NAME
DOB (Date of Birth)
ID#
Case #

Dear (Pres. of INS. CO.):

Residential placements services have been denied for our daughter against the recommendations of a qualified team of experts consistent with APA standard care guidelines. Documentation is available from our case manager (name). At this time, I would like you to put in writing that you (INS. CO.) are taking complete responsibility for my daughter’s life.

Respectfully,

YOUR NAME

Cc: Case manager
Medical manager

