Insurance Appeal Letter Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

An insurance appeal letter is a written request asking a health plan to reverse an adverse benefit determination: a denied, reduced, or terminated mental health claim. Clinicians, billing staff, patients, or representatives file it within the plan's appeal deadline, pairing the denial code with a clinical rebuttal. No law prescribes the format; the deadline is law.

Routing and header block name the track before you draft

Do: identify the track (ERISA, ACA, Medicare, Medicare Advantage, Medicaid); carry member IDs, claim numbers, dates of service, the denial date, and the word appeal.
Pitfall: a letter that never names the determination can be logged as a grievance, and grievances do not overturn denials.

The denial, quoted the CARC code, verbatim

Do: state what was denied and quote the reason code verbatim from the remittance advice or EOB; CO-50 and CO-197 are the most-rebutted codes.
Pitfall: appealing CO-16, which means missing information; fix that with a corrected claim, not an appeal.

Point-by-point rebuttal the plan's criteria, in order

Do: name the plan's medical-necessity policy and answer each criterion it applied, using its own guidelines (InterQual, MCG, LOCUS, or ASAM where used).
Pitfall: a general essay on why therapy helps; ignoring the stated rationale is a standard procedural loss.

Clinical evidence summary dated scores, concrete function

Do: diagnosis with its most specific ICD-10 code, measure scores with dates, functional impairment in concrete terms, treatment history, risk, plan goals.
Pitfall: undated scores; a lone PHQ-9 with no baseline gives the reviewer nothing to weigh.

Disclosure and parity requests (US plans) the records that set up round two

Do: request in writing the criteria used and every document relevant to the claim, free on an ERISA appeal, plus the NQTL comparative analysis (CAA-2021 sec. 203).
Pitfall: making parity the whole argument; it is a framing layer, and the clinical rebuttal leads.

Requested action and deadline language a request a reviewer can grant

Do: state the exact reversal wanted, pay the listed claims or authorize the services; note timeliness; ask for a written decision and reserve external review.
Pitfall: frustration without a grantable request; reviewers reverse determinations, they do not interpret complaints.

Signature, authorization, enclosures who signs, what rides along

Do: the filer signs the letter, the clinician signs the medical-necessity statement; attach CMS-1696 (Medicare), written consent (Medicaid), or a designation (ERISA, ACA).
Pitfall: the missing representative form is a top procedural dismissal; obtain it when the appeal is drafted.

Before it is filed

- [ ] Code quoted verbatim; rebuttal walks the plan's own policy
- [ ] Notice date, filing date, and window together on the page
- [ ] Representative authorization enclosed, not promised
- [ ] Improvement framed as dated scores with a taper endpoint
- [ ] Records request and NQTL analysis demand included
- [ ] Requested action names the claims or services to reverse

Drafting with AI

Bring the denial notice, the plan's policy name if known, dated measure scores, and the treatment plan; the letter is built around the code being rebutted.

"Draft a first-level appeal of a CO-50 denial of weekly 90834 sessions for F33.1: ERISA plan, timely filed, PHQ-9 18 to 12 with dates, taper endpoint 10/2026: …"

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

400 to 900 words	45 to 90 min by hand	After a denial	Payer appeals reviewers
one to three pages	clinical team estimate	within the filing deadline	who reads it

Full guide, sample letter, and compliance notes:
bastiongpt.com/template/insurance-appeal-letter

Insurance Appeal Letter Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

From (filer): name, role or credentials, practice, address, phone:

Date: Sent via (portal / fax / certified mail):

To: plan appeals department and address, exactly as shown on the denial notice:

Patient name: Member ID: Group #:

RE: Appeal of adverse benefit determination

Denial reference · quote the code from the remittance advice or EOB · timeliness is arithmetic: put the dates on the page

Claim #(s): Date(s) of service:

Denial notice date: Denial code(s) (CARC), quoted verbatim:

Appeal window per notice (days): File by (notice date + window): Filed on:

☐ Expedited review requested (state the urgent clinical basis in section 3)

1) Determination appealed

Service, units, and dates · what was denied, reduced, or terminated, in the notice's own words

2) Why the denial is wrong

Name the plan's medical-necessity policy · rebut each criterion it applied, in order (InterQual, MCG, LOCUS, or ASAM where used)

3) Clinical support

Diagnosis with ICD-10 code · measure scores with dates · functional impairment · treatment history · risk factors · plan goals

4) Records requested

The criteria applied · all documents relevant to the claim · for US mental health denials, the NQTL comparative analysis (CAA-2021 section 203)

5) Requested action

Reverse the determination and pay the listed claims, or authorize the services · state that the appeal is timely · ask for a written decision with external review instructions

Signature (filer): Name / credentials: Date:

Filed by: ☐ patient ☐ provider ☐ authorized representative · ☐ Authorization enclosed (CMS-1696 / written consent / designation)

Enclosures (check and number each)

☐ Denial notice ☐ Representative authorization ☐ Medical-necessity statement
☐ Treatment plan and latest review ☐ Measure log with dates ☐ Relevant records