APTA Template: Consumer/Patient Utilization Management Advocacy Template

Insert the applicable information in brackets before sharing with a patient/consumer.

**REMINDER**: Delete all text above, including these instructions, before sharing with patient/consumer.

**Know Your Appeal Rights**

Your insurance company has hired a third party to authorize therapy benefits. This company is [UM VENDOR NAME]. Many public and private health plans including Medicaid, Medicare Advantage, and individual and employer sponsored plans use utilization management companies to determine whether the care being provided to you is medically necessary.

**What are we doing for you?**

Our administrative and professional therapy staff are working tirelessly on your behalf to ensure medically necessary services are authorized. We provide all necessary documentation and communicate regularly with is [UM VENDOR NAME] and, if necessary, with your insurer. As your clinician, we will provide you with our professional clinical judgement regarding your care and support you in seeking appropriate coverage.

**What does this mean for you?**

[UM VENDOR NAME] requires your therapist to fill out forms to authorize all therapy treatment, except for your initial evaluation. In some cases, it may take [UM VENDOR NAME] several days to respond to our request for therapy visits for you and your family. As a result, your treatment with us may be **delayed, modified, or denied**.

**What will happen if your treatment is delayed, modified, or denied?**

If our office receives notice that your treatment has been modified or denied, we will make every effort to appeal [UM VENDOR NAME]’s determination on your behalf. However, please be aware that we cannot guarantee that the denial will be overturned on appeal.

If you believe your medically necessary treatment has been delayed, denied, or inappropriately restricted and *we are unable to appeal on your behalf*, **you** have the right to request an appeal to resolve differences with your plan. You have the right to ask your plan to pay for therapy services you believe should be covered. If you decide to submit an appeal, make sure to keep a copy of everything you send to your plan as part of that appeal. At each level of appeal, you will receive a decision letter with instructions on how to move to the next level of appeal. If we can assist you in any way with filing an appeal, please let our staff know.

**What can *you* do to advocate for yourself if you think your care has been delayed or necessary services impeded or denied?**

If your appeal is unsuccessful, or you would like information about your health coverage options, you may be able to reach out to a consumer assistance program in your state. These programs play a critical role in ensuring that consumers can find health insurance and access to the benefits to which they are entitled. However, not all states have consumer assistance programs. General information can be found on the federal government’s Center for Consumer Information and Insurance Oversight’s webpage: [Consumer Assistance Program](https://www.cms.gov/cciio/resources/consumer-assistance-grants/). In the case of an employer-sponsored plan, you may want to consult with your human resources department.

While filing appeals and registering complaints isn’t easy, it is the most effective way to ensure you and other beneficiaries have access to the medically necessary care you deserve.

**It is your right to have your opinion heard.**