GLUTEN HERO

Insurance Appeal Letter—internal appeal of a denied celiac claim

Internal Appeal of Denied Claim—Celiac Disease

Your contact information

[Your Full Name]

[Your Address]

[City, State, ZIP]

[Phone Number]

[Email Address]

Date: [MM/DD/YYYY]

Insurance company

[Insurance Company Name]

Attn: Appeals Department

[Insurance Company Address]

[City, State, ZIP]

RE: Internal Appeal of Denied Claim

Member Name: [Patient Name]

Member ID / Subscriber Number: [Member ID]

Group Number (if applicable): [Group Number]

Claim Number: [Claim Number from EOB]

Date(s) of Service: [MM/DD/YYYY]

Provider: [Treating Provider Name and NPI]

Denied Service: [Brief description, e.g., “Follow-up upper endoscopy for celiac monitoring”]

Stated Reason for Denial: [Quote directly from the denial letter]

Dear Appeals Reviewer:

I am writing to formally appeal the denial of the above-referenced claim. I respectfully request that this denial be overturned and the claim approved as a covered medical expense.

1. The Diagnosis

I have been diagnosed with celiac disease (ICD-10 code K90.0), confirmed on [DATE OF DIAGNOSIS] by [METHOD: e.g., positive serology including tTG-IgA antibodies and confirmatory upper endoscopy with biopsy demonstrating villous atrophy]. Celiac disease is a chronic, lifelong autoimmune condition that requires ongoing medical management, including periodic monitoring,

repeat diagnostic testing when clinically indicated, and treatment of associated complications.

A copy of the diagnosis records and current treatment summary is enclosed as Attachment A.

2. The Medical Necessity of the Denied Service

The service denied ([describe the denied service in plain language]) was prescribed by my treating physician, [Provider Name], on [Date of Order] for the following clinically necessary purposes:

- [Reason 1: e.g., to monitor mucosal healing on a strict gluten free diet, the standard of care for adult celiac patients]
- [Reason 2: e.g., to investigate persistent symptoms despite strict adherence, which raises concern for refractory celiac disease]
- [Reason 3: e.g., to evaluate for celiac-associated comorbidities including iron deficiency anemia, vitamin D deficiency, and bone density loss]

A clinical letter from my treating physician supporting medical necessity is enclosed as Attachment B.

3. The Standard of Care

Keep the paragraph below that matches your denied service; delete the others.

Follow-up endoscopy: Repeat upper endoscopy with biopsy is the standard method for evaluating mucosal healing in celiac disease patients with persistent or recurrent symptoms, and is recognized by major gastroenterology societies as an appropriate component of celiac follow-up care.

Nutrition counseling: Medical nutrition therapy provided by a registered dietitian is the cornerstone of celiac treatment. The gluten free diet is medically necessary, and MNT is the recognized clinical service for ensuring adherence and adequate nutrition (ICD-10 K90.0 with the relevant MNT CPT codes).

DEXA scan: Bone mineral density screening is part of standard celiac management because patients are at elevated risk of osteopenia and osteoporosis due to malabsorption. DEXA scanning at diagnosis and at clinically indicated intervals is standard of care.

Prescribed supplements: The prescribed supplements are a direct medical response to documented deficiencies caused by celiac-induced malabsorption ([list deficiencies]). They are prescribed in writing by my treating physician, not over-the-counter consumer products.

4. The Plan’s Own Coverage Terms

I have reviewed my plan documents. [Cite the specific coverage section if you can find it, e.g., “Section X.Y of the Member Handbook specifies that medically necessary diagnostic and therapeutic services for chronic conditions are covered when prescribed by a network provider.”] The denied service falls squarely within this coverage provision.

5. The ACA Framework

Under the Affordable Care Act, all health plans must cover essential health benefits and provide a clear, fair appeal process. I am exercising my right to internal appeal as set forth in my plan documents and in 29 CFR sec. 2560.503-1 (for ERISA-covered plans) or applicable state insurance law.

I respectfully request that this appeal be reviewed by a qualified medical professional with experience in celiac disease and gastroenterology, as required by the ACA's clinical-peer review standards.

6. The Specific Relief Requested

I am asking the plan to:

- Reverse the denial of the above-referenced claim.
- Pay the claim in full, less any applicable in-network deductible or coinsurance.
- Provide written notice of the reversal within the timeframe required by ACA appeal rules (30 days pre-service, 60 days post-service).

If this appeal is denied, please provide the specific clinical rationale, the professional credentials of the reviewer, and a clear explanation of my external review rights including the deadline and contact information for the Independent Review Organization.

7. Attachments

- Attachment A: Celiac diagnosis records (lab results, biopsy reports)
- Attachment B: Treating physician's letter supporting medical necessity
- Attachment C: Copy of original denial letter or EOB
- Attachment D: [Any other supporting records]

I appreciate your prompt and careful review. I am available at the contact information above to provide any additional information needed.

Sincerely,

[Your Printed Name]

[Date]

General educational template, not legal or tax advice. Deadlines and procedures vary by plan and state. Confirm your appeal rights and deadlines in your plan documents and on your denial letter.