Tennessee Medical Association

701 Bradford Avenue
Nashville, TN 37204
TF 800.659.1862
F 615.312.1892
tnmed.org

ERISA Appeals Letter
Second Level Appeal/Ignored Claim

[Date]

[Employer Plan Administrator]
[Address]

RE: [Patient Name
Patient Address
Patient Phone Number
Patient DOB
Patient SSN/Health Plan ID
Group Policy Numbers]

To whom it may concern:

This letter is to notify you that I am acting as the authorized representative for the above indicated patient and am submitting this second level appeal for the reasons indicated below. Enclosed please find a copy of the patient signed Assignment of Benefits Form, authorizing me to act as the patient's representative in this appeal. In addition, due to [Plan Administrator's] continued failure to respond to our claims and/or first level appeal, you are currently in violation of ERISA regulations. If this second appeal is ignored, we reserve the right to pursue legal action.

In accordance with [Plan Administrator] appeals procedures, I am sending this second level appeal letter to appeal the denial of a claim sent xx/xx/xxxx for services provided to the above indicated patient on xx/xx/xxxx. Please find enclosed our first level appeal letter, which was sent on xx/xx/xxxx, as well as the original claim and supporting documentation.

In response to this appeal and in review of the denied claim, you are required to comply with federal regulations 29 CFR 2650.530-1(j)-(g), which require sufficient reasoning for the denied claim. Upon receipt of this appeal letter, you have 30 days to review the appeal and send notification of [Plan Administrator's] benefit determination on appeal to the address indicated below. 29 CFR §2560.503-1(i)(2)

If you do not provide sufficient reasoning for the denied claim or if you fail to respond to this appeal, I reserve the right to pursue legal action in court, regardless of whether I have exhausted the administrative remedies. 29 CFR §2560.503-1(l). At a trial, the court will

determine whether [Plan Administrator] abused its discretion in making the denial. In making this determination, courts have considered such factors as:

- Whether the plan had a conflict of interest
- Inconsistent reasons for denial of same services
- Failure to provide full review of claim
- Failure to follow proper procedures in denying claim. *Harlick v. Blue Shield of California*, 686 F. 3d 699 (9th Cir. 2012).

It is our opinion that we have sufficient evidence to prove one or more of these factors.

Please note that federal law prohibits [Plan Administrator] from taking any retaliatory actions against me, my practice, or the above indicated patient. 29 USC §1140. If any such action is taken, the injured party will file a complaint with the US Department of Labor and will be entitled to injunctive relief.

As authorized representative for the above indicated patient, I request full reimbursement of the previously denied claim described above. Please see attached documentation for further explanation.

Sincerely,

[Treating Physician]