

## **FORM TO REQUEST DOCUMENTATION FROM AN EMPLOYER-SPONSORED HEALTH PLAN OR A GROUP OR INDIVIDUAL MARKET INSURER CONCERNING TREATMENT LIMITATIONS**

*Background:* This is a tool to help you request information from your employer-sponsored health plan or your group or individual market insurer regarding treatment limitations that may affect your access to mental health or substance use disorder benefits. You can use this form to request:

- **General information** about treatment limitations, like your plan’s preauthorization policies for both medical/surgical and mental health treatment.
- **Specific information** about why benefits were denied. For example, you can ask about the criteria for “failure to show medical necessity” that your health insurance company may have used to deny your claim.

Your plan or insurer is required by law to provide you this information in certain instances. In some cases, a request can result in more information than you may want. Talk to your plan or insurer about what documents you wish to request, and, if you prefer, how you can receive the documents electronically.

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), many health plans and insurers must make sure that there is “parity” between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

If you, a family member, or someone you are helping obtains health coverage through a private employer health plan, federal law requires the plan to provide certain plan documents about your or their benefits, including coverage limitations on those benefits, on request. For example, you may want to obtain documentation as to why your health plan is requiring pre-authorization for visits to a therapist before it will cover the visits. Generally, private employer plans must provide the documents within thirty (30) calendar days of the plan’s receipt of your request.

**Contact your health plan or health insurance company directly to submit your request.**

This form is designed to help you request information from your plan about treatment limitations. Many common types of treatment limits are listed on this form. If the type of treatment limitations being imposed by your plan does not appear on the list, you may insert a

description of the treatment limitation about which you would like more information under “Other.”

**Instructions:** Complete the attached form to request general information from your plan or insurer about treatment limitations or specific information about why your mental health or substance use disorder benefits were denied. This information may help you appeal a claim denial, but you must separately initiate the plan’s general review and appeals process if you want to appeal the claim denial with your plan or insurer. You do not have to use this form to request information from your plan. Consult your summary plan description (SPD) or certificate of coverage to see how to request information from the plan, or how to appeal a denied claim.

If you are helping someone request information about his/her health coverage, a plan or insurer may require you to submit, with your request for information, additional documentation signed by the person you are helping (if you have not already done so).

If you have any questions about this form and you are enrolled in a private employer health plan, you may visit the Employee Benefits Security Administration’s (EBSA’s) website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) for answers to common questions about private employer health plans. You may also contact EBSA electronically at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call toll free 1-866-444-3272.

You can also use this form if you are enrolled in coverage that is not through a private employer health plan—for example, if you have individual health coverage or coverage sponsored by a public sector employer, like a city or state government. You may contact the Centers for Medicare & Medicaid Services (CMS) at [phig@cms.hhs.gov](mailto:phig@cms.hhs.gov) or 1-877-267-2323 ext. 61565 for questions about your individual health coverage or public sector health plan.

## **PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1080. This information collection may be used, but is not required to be used, by group health plan participants, beneficiaries, covered individuals in the individual market or persons acting on their behalf, to request information regarding treatment limitations from health plans. This form aims to simplify the process of requesting relevant disclosures for patients and their authorized representatives. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. The use of this information collection is voluntary. This is a third party disclosure and the issue of confidentiality between third parties is out of scope for the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850, or [jose.gomez1@cms.hhs.gov](mailto:jose.gomez1@cms.hhs.gov).

Date: \_\_\_\_\_

### **Mental Health and Substance Use Disorder Parity Disclosure Request**

**NOTE:** This disclosure request form is NOT designed to initiate a formal claim for benefits or an appeal of a denied claim; however, the information obtained through this form may help you appeal a medical claim denial with respect to your mental health and substance use disorder benefits. Submitting this form is voluntary and does NOT replace your health plan's claims or appeals process.

To: \_\_\_\_\_ [*Insert name of the health plan or issuer*]

*(If you are a provider or another representative who is authorized to request information for the individual enrolled in the plan, provide the information below.)*

I am an authorized representative requesting information for the following individual enrolled in the plan:

Attached to this request is an authorization signed by the enrollee.

*(Complete this section if you're requesting general information about treatment limitations.)*

#### **General Information Request**

- ☐ I am requesting information concerning the plan's limitations related to coverage for:
  - ☐ Mental health and substance use disorder benefits, generally.
  - ☐ The following specific treatment for my mental health condition or substance use disorder: \_\_\_\_\_.

*(Complete this section if you're requesting specific information about limitations that led to a denial of benefits.)*

### **Claim/Denial Information Request**

- ☐ I was notified on \_\_\_\_\_[*Insert date of denial*] that a claim for coverage of treatment for \_\_\_\_\_[*Insert mental health condition or substance use disorder*] was, or may be, denied or restricted for the following reason[s] shown immediately below:

*(Based on your understanding of the denial of, limitation on, or reduction in coverage, check all that apply)*

- ☐ I was advised that the treatment was not medically necessary.
- ☐ I was advised that the treatment was experimental or investigative.
- ☐ The plan requires authorization before it will cover the treatment.
- ☐ The plan requires ongoing authorizations before it will cover my continued treatment.
- ☐ The plan is requiring me to try a different treatment before authorizing the treatment that my doctor or therapist recommends.
- ☐ The plan will not authorize any more treatments based on the fact that I failed to complete a prior course of treatment.
- ☐ The plan's prescription drug formulary does not cover the medication my doctor is prescribing.
- ☐ My plan covers my mental health or substance use disorder treatment, but does not have any reasonably accessible in-network providers for that treatment.
- ☐ I am not sure whether my plan's calculation of payment for out-of-network services, such as its methods for determining usual, customary and reasonable charges, complies with parity protections.
- ☐ Other: (*Specify basis for denial of, limitation on, or reduction in coverage*):

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Because my health coverage is subject to the parity protections, financial requirements or treatment limitations cannot be applied to mental health or substance use disorder benefits unless those limits are comparable to financial requirements or treatment limitations applied to medical and surgical benefits. Therefore, for the limitations or terms of the benefit plan specified above, **within thirty (30) calendar days from the date of receipt of this request**, I request that the plan:

- ☐ 1. Provide the specific plan language regarding the limitation(s) and identify the medical/surgical and mental health or substance use disorder benefits to which it applies in the relevant benefit classification described in the regulations under the Mental Health Parity and Addiction Equity Act;
- ☐ 2. Identify the factors used in the development of the limitation(s) (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment);
- ☐ 3. Identify the sources (including any processes, strategies, evidentiary standards) used to evaluate the factors identified above. Examples of evidentiary standards include, but are not limited to, the following:
  - Excessive utilization as defined by two standard deviations above average utilization per episode of care;
  - Recent medical cost escalation as defined by medical costs for certain services increasing 10% or more per year for 2 years;
  - High variability in cost per episode of care as defined by episodes of outpatient care being 2 standard deviations higher in total costs than the average cost per episode 20% or more of the time in a 12-month period; and
  - Safety and efficacy of treatment modality as defined by 2 random clinical trials required to establish that a treatment is not experimental or investigative;
- ☐ 4. Identify the methods and analysis used in the development of the limitation(s); and
- ☐ 5. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

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Printed Name of Individual Enrolled in the Plan or his or her Authorized Representative

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Signature of Individual Enrolled in the Plan or his or her Authorized Representative

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Member Number (*number assigned to the enrolled individual by the Plan*)

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Claim Number (*if seeking information regarding a specific claim*)

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Address

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Date

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E-mail address (if email is a preferred method of contact)