

A Denial or Unexpected Bill: What to Do Next

Start with the document you received. A bill, an insurance decision and an estimate can lead to different next steps. Find the service, the reason and any deadline. Keep copies so you do not have to explain the whole issue on every call.

Separate the Documents [2]

Document or answer	Question to ask
Provider bill	Which service and date is this for? Ask for itemized charges. Is this the final balance, and was it sent to my plan?
Explanation of benefits (EOB)	This is not a bill. It shows how insurance processed a claim and what you may owe. Compare it with the provider bill.
Coverage denial	What was denied, why, and what review rights and deadlines are listed? A billing correction is different from an appeal.
Estimate from before care	What changed? If you did not use insurance, keep the written good faith estimate as well as the bill.
Verbal answer	Can you send the reason, next step and deadline in writing?

When the health plan denied coverage [1] [3] [4]

An internal appeal asks the insurer to reconsider. External review uses an independent third party when the decision qualifies. HealthCare.gov describes these routes for health-plan decisions. Follow the notice and your plan's process, including any urgent-review option. Do not copy a deadline from a different plan or from the separate self-pay dispute below. Ask the treating clinician whether supporting medical information is needed. If you have Medicare, use its appeal instructions. For Medicaid, contact your plan or state agency about the route on your notice. [1] [3] [4]

Gather These Before the Call

- The notice or bill, service date, provider name, claim or reference number and the stated reason.
- Every deadline on the notice or bill. Ask what must be submitted or received by that date, where to send it and how to prove receipt.

- The estimate, prior authorization, referral or coverage answer you already received, if relevant.
- The correction or explanation you are asking for. Ask the treating clinician whether supporting information is needed.

An opening line for the plan

Original script: "I received a denial for [service/date]. Please explain the reason and which appeal process applies. What do I need to submit, where, and by when? If my clinician believes waiting could seriously harm my health, how do we request urgent review?" If care is needed now, contact the treating team about the immediate care plan while the coverage issue is reviewed. [3]

When the problem is the bill itself [5] [6] [7]

- If you did not use insurance: CMS has a separate patient-provider dispute process for some bills at least \$400 above that provider's written good faith estimate. Its listed criteria include telling the provider before care that insurance would not be used, care on or after January 1, 2022, an estimate received at least three days before the scheduled appointment, and an initial bill dated within the last 120 calendar days. There is a \$25 nonrefundable filing fee. Check the CMS criteria or call 1-800-985-3059 before assuming you qualify. This is not an insurance appeal.
- If you used private insurance: federal surprise-billing protections apply in specified settings, including most emergency care, certain out-of-network services at in-network hospitals, hospital outpatient departments or ambulatory surgical centers, and air ambulances. They do not cover every unexpected treatment bill. Ground ambulances and other settings have different rules or exceptions. Use the CMS guidance to check your situation.
- If you cannot afford the bill: ask the billing office for its financial-assistance policy, eligibility rules, application, deadline and a contact for help. Nonprofit hospitals must assist eligible patients who cannot afford care. Other facilities may offer help, but do not assume every rehab program has the same obligation. Ask about payment arrangements if assistance is unavailable.
- Keep the questions separate: request correction of a billing error, pursue the applicable coverage review, and ask about assistance as needed. Ask what happens to the bill while each request is pending. Do not assume a call, a complaint or an assistance request pauses payment, collection or appeal deadlines.

Keep notes private. Write or type short notes. Use another copy if you need more room. Save and reopen the PDF to check your answers.

Your Review Record

Decision, reason and deadline

Reason, amount if relevant, deadline and where it came from. Keep each process separate.

People contacted and their answers

Date, department, name, reference number and what they agreed to do.

Documents and next action

What, to whom, by when, proof of receipt, who follows up and any unresolved question.

Find the right help

[HealthCare.gov: internal and external appeals](https://www.healthcare.gov/appeal-insurance-company-decision/)

<https://www.healthcare.gov/appeal-insurance-company-decision/>

[Paying for rehab](https://www.addictionhelp.com/drug-rehab/paying-for-rehab/)

<https://www.addictionhelp.com/drug-rehab/paying-for-rehab/>

[CMS: find an action plan for your medical bill](https://www.cms.gov/initiatives/your-patient-rights/medical-bill-rights/get-help/find-action-plan)

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Keep notes private. Use approved channels to share documents. This guide does not determine coverage or legal rights. Check source details.

Sources

- [1] [HealthCare.gov: Appealing a Health Plan Decision](https://www.healthcare.gov/appeal-insurance-company-decision/) (healthcare.gov)
- [2] [Texas Department of Insurance: Understanding an EOB](https://tdi.texas.gov) (tdi.texas.gov)
- [3] [HealthCare.gov: Appealing an insurance company decision](https://www.healthcare.gov/appeal-insurance-company-decision/) (healthcare.gov)
- [4] [Medicare: Filing an appeal](https://www.medicare.gov) (medicare.gov)
- [5] [CMS: Dispute a medical bill](https://www.cms.gov) (cms.gov)
- [6] [CMS: Medical bill rights when using insurance](https://www.cms.gov) (cms.gov)
- [7] [CMS: Apply for medical bill financial assistance](https://www.cms.gov) (cms.gov)