VIA FACSIMILE AND U.S. MAIL

Appeals Department
XYZ Insurance Company [or Self-Insured Group Plan Third Party Administrator]
ADDRESS

RE: CLIENT (DOB xx/xx/xxxx)
XYZ Health Plan ID #
NAME OF EMPLOYER GROUP HEALTH PLAN (if applicable)
REQUEST FOR DOCUMENTS RE ADVERSE DETERMINATION

Dear [NAME OF CONTACT OR SIR OR MADAM]:

Enclosed please find the XYZ Insurance Company Authorization to Disclose Protected Health Information signed by CLIENT. By letter dated xx/xx/xxxx, XYZ Insurance Company issued an adverse determination [final adverse determination] with respect to CLIENT's treatment at PROVIDER/FACILITY. (Copy of adverse determination attached.) CLIENT intends to file an internal appeal [or request for external review if final adverse determination] by the applicable deadline. **THIS LETTER DOES NOT CONSTITUTE THE APPEAL [EXTERNAL REVIEW REQUEST].**

CLIENT hereby requests that copies of his/her claim file and all other documents relevant to the claim at issue be sent to me as his/her attorney, including but not limited to:

a) The reason for the denial [termination] of coverage for the proposed or ongoing treatment;
b) any rule, benefit provision, guideline, criteria or protocol upon which the adverse decision was based;
c) billing and service code information; and
d) communications within XYZ Insurance Company and between XYZ Insurance Company and others, including agents or employees of the NAME OF EMPLOYER GROUP HEALTH PLAN.

This request covers all documents, records and information submitted, considered, or generated in the course of the benefit determination, *without regard to* whether such documents, records or information were relied upon in making the benefit determination. *See* 29 CFR § 2560.503-1(m)(8) [cite to PHSA regulation 45 CFR 147.136 ((b)(2) group or (b)(3) non-group) if a non-group or non-federal governmental plan].

CLIENT further requests, pursuant to 29 CFR § 2590.712(d)(3) [cite to PHSA regulation 45 CFR 146.136(d)(3) if a non-group or non-federal governmental plan], disclosure of all information relevant to medical/surgical, mental health, and substance use disorder benefits for purposes of evaluating XYZ Insurance Company's [if self-insured, NAME OF EMPLOYER GROUP HEALTH PLAN's] compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) in the handling of CLIENT's claim. This request includes documents with information on medical necessity criteria for *both* medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used by XYZ to apply a nonquantitative

treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Plan.

Kindly send me all of the requested documents via mail, fax or email no later than 30 days from your receipt of this letter. Please contact me by phone (NUMBER) or email (ADDRESS) if you have any questions about this request.

Sincerely yours,

Enclosures: [Release, adverse determination]

cc: CLIENT