

Checklist for Appealing Denied Claims

- Review the Explanation of Benefits (EOB) to determine the reason for the claim denial.**
- Verify that the claim form was completed and submitted correctly.**
 - o If the denial was due to a technical billing error (eg, incorrect patient identification number, missing diagnosis), correct the error(s) or omissions and resubmit the claim.
- Verify the payer's requirements for appealing a claim:**
 - o Does the payer require the use of a specific form?
 - o Can the appeal be conducted over the phone, or must it be in writing?
 - o If the appeal must be in writing, to whom should it be directed?
 - o What information needs to be included with the appeal (eg, copy of original claim, EOB, supporting documentation)?
 - o How long does the appeal process take?
 - o How will the payer communicate the appeal's decision?
- Write an appeal letter and review to confirm accuracy and completeness, including patient identification numbers and relevant documentation regarding treatment decisions, such as:**
 - o Patient's medical history
 - o Physician's clinical notes detailing the relevant diagnosis
 - o Previously tried treatments/therapies and reasons for discontinuation
 - o Full Prescribing Information
 - o Medical literature regarding the use of the product for the patient's diagnosis
- File the appeal as soon as possible and within filing time limits.**

This checklist is offered for informational purposes only and is not intended to provide reimbursement or legal advice. Each healthcare provider is responsible for determining the appropriate codes, coverage, and payment for individual patients. Astellas does not guarantee third-party coverage or payment or reimbursement for denied claims.



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