

NAVIGATING MEDICAID WAIVER APPEALS AND INSURANCE DENIALS

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PLAN FOR TODAY

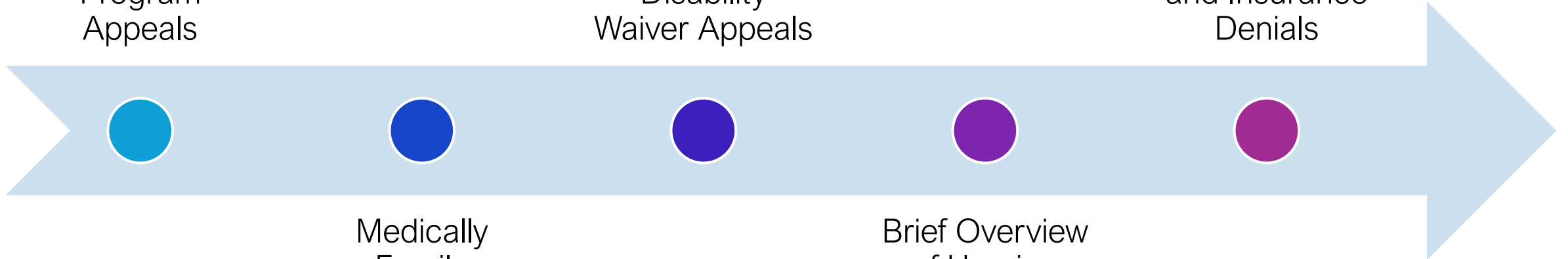
DRS Home
Services
Program
Appeals

PUNS and
Developmental
Disability
Waiver Appeals

Medicaid,
Managed Care,
and Insurance
Denials

Medically
Fragile
Technology
Dependent
Waiver (MFTD)
Appeals

Brief Overview
of Hearing
Process



WHAT PROGRAMS ARE WE TALKING ABOUT?

Division of Rehabilitation Services (DRS) Home Services Program

- Three Medicaid waivers and state-funded Home and Community Based Services
- For those with severe disabilities that limit activities of daily living

Medically Fragile Technology Dependent (MFTD) Waiver

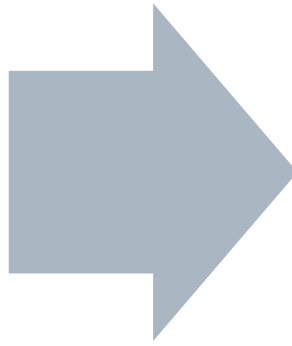
- A waiver for those with both medical complexity and medical technology like a tracheostomy or feeding tube

Developmental Disability (DD) Waivers

- Three waivers for children and adults
- Accessed by the PUNS waiting list
- Provide either home-based or residential services

WHAT ARE WE SEEING?

No systemic negative
changes to Medicaid
waivers or
programs/services



However:

- More cuts to hours/budgets in MFTD and DRS waivers
- Stricter evaluation process and criteria for PUNS list
- Stricter administration of tools in all waivers
- More frequent equipment, device, supply, and service denials

DRS HOME SERVICES PROGRAM APPEALS

TOPICS FOR APPEALS – HOME SERVICES PROGRAM

01

DENIALS

- Applied for the DRS Home Services Program and denied because the individual did not score enough points (>29) on the Determination of Need (DON) Tool

02

CUTS

- Individuals who have had their hours, funding, or services cut

03

UNMET NEED

- Individuals who did not show or had reduced "unmet need for care"

DRS: THINGS THAT CANNOT BE APPEALED

If your assets are too high, assuming they applied the rules correctly

- \$35,000 per family/\$17,500 individual



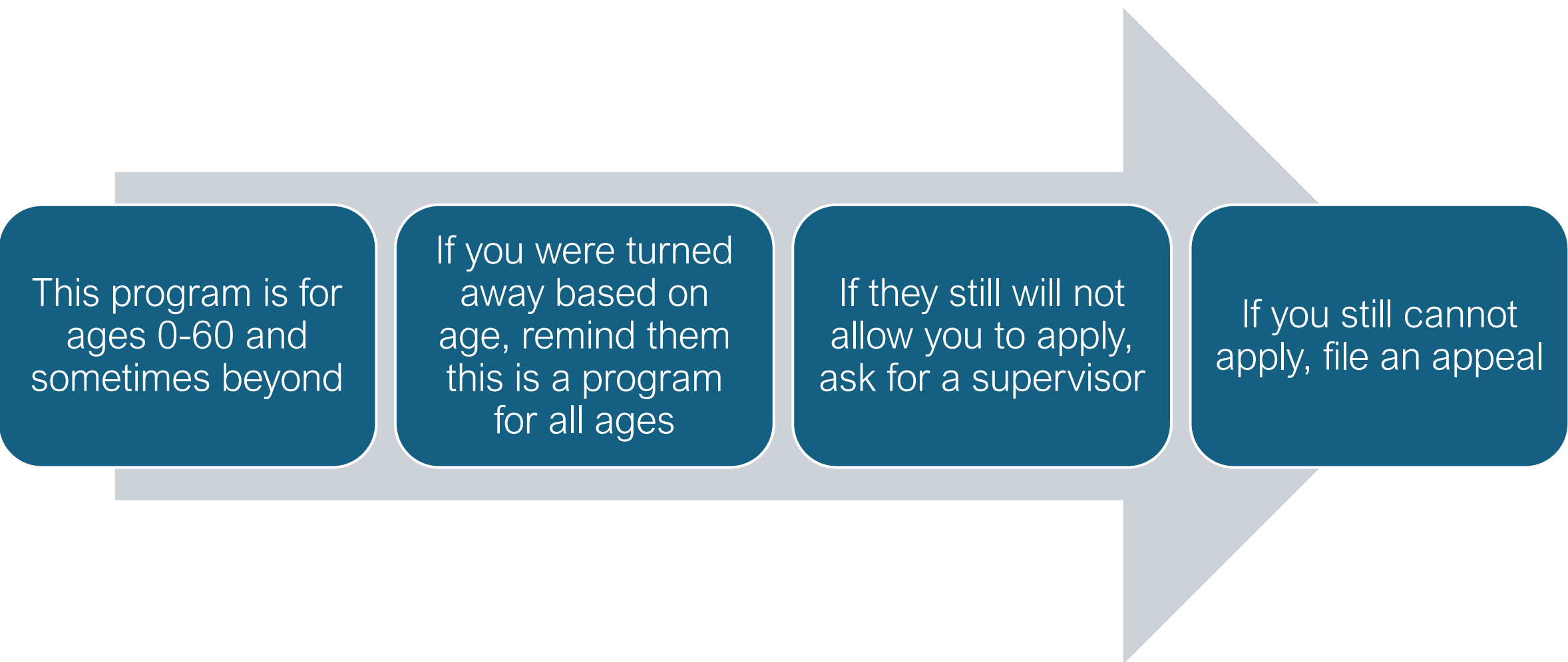
If your income is too high and you want to be in a waiver with Medicaid coverage

- People who cannot qualify financially for Medicaid can still get some state-funded services through this program if they meet asset limits



If you don't live in Illinois or do not have citizenship or legal status

DID YOU GET TURNED AWAY DUE TO AGE?



This program is for
ages 0-60 and
sometimes beyond

If you were turned
away based on
age, remind them
this is a program
for all ages

If they still will not
allow you to apply,
ask for a supervisor

If you still cannot
apply, file an appeal

DETERMINATION OF NEED (DON) TOOL

To qualify, you need to score 29 points or more on the DON Tool:

- Mini Mental Exam (ages 12+)
- Functional Assessment Level of Impairment
- Functional Assessment Unmet Need for Care

DETERMINATION OF NEED FUNCTIONAL ASSESSMENT

Function	Level of Impairment	Unmet Need for Care	Case Comments: Identify resources, describe special needs and circumstances that should be taken into account when developing a care plan
1. Eating	0 1 2 3	0 1 2 3	
2. Bathing	0 1 2 3	0 1 2 3	
3. Grooming	0 1 2 3	0 1 2 3	
4. Dressing	0 1 2 3	0 1 2 3	
5. Transferring	0 1 2 3	0 1 2 3	
6. Continence	0 1 2 3	0 1 2 3	
7. Managing Money	0 1 2 3	0 1 2 3	
8. Telephoning	0 1 2 3	0 1 2 3	
9. Preparing Meals	0 1 2 3	0 1 2 3	
10. Laundry	0 1 2 3	0 1 2 3	
11. Housework	0 1 2 3	0 1 2 3	
12. Outside Home	0 1 2 3	0 1 2 3	
13. Routine Health	0 1 2 3	0 1 2 3	
14. Special Health	0 1 2 3	0 1 2 3	
15. Being Alone	0 1 2 3	0 1 2 3	
Box A: Subtotal Col A, Items 1-6	Box A	Box B	Box B: Subtotal Col B, Items 1-6
Box C: Subtotal Col A., Items 7 - 15	Box C	Box D	Box D: Subtotal Col B, Items 7 - 15
Box E: Subtotal Box A & Box C	Box E	Box F	Box F: Subtotal Box B & Box D
		Box G	Box G: Subtotal Box E & Box F

- Form is now electronic, but questions are the same
- You can view the [old paper form and scoring guide here](#)

TIPS FOR MAXIMIZING YOUR DON SCORE

Describe a difficult day – this is not the time to celebrate your loved one's independence!

Make sure you indicate when prompting, encouragement, or guidance are needed for a task – often you can score 1 or 2 points

For Unmet Need, make sure you do not say you are always able to meet your loved one's needs! Note the following:

- When you are working or volunteering
- Other tasks, such as caring for siblings or other family members
- When your health does not permit you to provide care
- That you are having difficulty meeting the needs of your child
- That your loved one's needs are overwhelming or burdensome

There is a fine line between asking for help and being perceived as neglecting your loved one – be careful!

KIDS AND DRS

Children of ALL
ages are eligible
for DRS Home
Services Program

However, DRS believes
care for children, even
when extraordinary, is
the parent's
responsibility

Official DRS
training slides



SCORING KIDS ON THE DON

Children are scored in comparison to a child the same age without a disability, and are scored a zero if a same-age child would also need assistance with a task

DRS case workers typically have low expectations of what young children can do; scoring can also be inconsistent

Children should receive additional points in the “Unmet Need” column if their needs create an additional burden on their caregiver; scoring is often inconsistent

Most young children cannot receive points on Instrumental Activities of Daily Living questions due to age

Tip: Explain how your child needs more assistance than a same-age peer, even if both may need some help with a task.



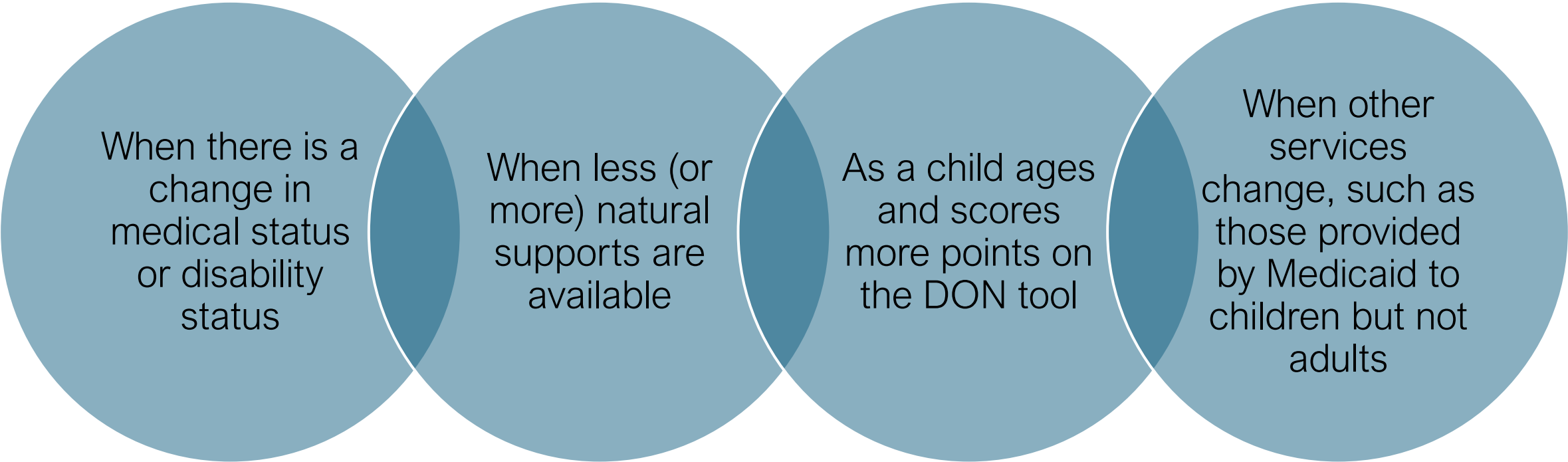
- Same-age peer: needs help rinsing hair in the bathtub
- Child with disability: needs to be lifted in/out, total washing assistance, total hair washing assistance, total drying

2) On Part B, determine the **additional burden** placed on a caregiver providing the service. If, because of the individual's age, there is **no increased burden**, a score of "0" should be given. If there is an **increased burden** on the caregiver due to the individual's disability, score "1", "2", or "3" according to the increased level of burden in providing the task.

Defining Undue Burden

- Additional effort expended by parents to fulfill their responsibilities for caregiving and nurturing of a child with a disability, far exceeding that which is typically necessary to complete the same caregiving and nurturing of a child without a disability.
 - An increased difficulty beyond which might already be expected.

WHEN CAN HOURS BE CHANGED?



When there is a
change in
medical status
or disability
status

When less (or
more) natural
supports are
available

As a child ages
and scores
more points on
the DON tool

When other
services
change, such as
those provided
by Medicaid to
children but not
adults

COMMON REASONS WE ARE SEEING HOURS BEING CUT

Individual lives with parents and should have natural supports in the evenings and on weekends, or parent is present in home and therefore there is no need for services

How to argue

- Individual's needs present an undue burden on the caregiver
- Caregiver has other responsibilities
- Caregiver is incapable of providing care

Individual is too young to score enough points, or individual receives no/minimal points in the Unmet Need for Care column

How to argue

- Bar should not be when a same-age peer is independent on a task, but rather when the disability makes the child less independent than a same-age peer
- Score undue burden on caregiver even if caregiver is present or legally responsible – additional effort required by the parent due to the disability

HOW TO FILE AN APPEAL (DHS APPEAL)

Appeal within 10 days to keep your current services in place, if applicable

- Otherwise, appeal within 30 days (35 days if notice was received by mail)

File your appeal in writing by a method that creates a paper trail: online, email, certified letter, etc.

Request copies of your scored DON tool and any other records leading to the decision

If your services are being coordinated by an MCO, you need to appeal through the MCO first

- MCOs don't always follow rules about due process – you may or may not receive formal notice and appeal information
- Each MCO has its own appeal process – request information on how to appeal – [MCO Appeals Info](#)
- To retain your current services, you must appeal within 10 days. If you do not hear from your MCO in 10 days, file a state appeal.

Resources

- [DRS Appeal Form](#) – optional but makes the process easier
- [Appeal FAQ from DRS](#)
- [Equip for Equality Appeal Guide](#)

INFORMAL RESOLUTION CONFERENCE (OPTIONAL)

Meeting held before a hearing to try to resolve your issues less formally



Always worth a try!



Usually with caseworker and a supervisor from DRS



If you agree with the resolution, both you and DRS must put the resolution in writing

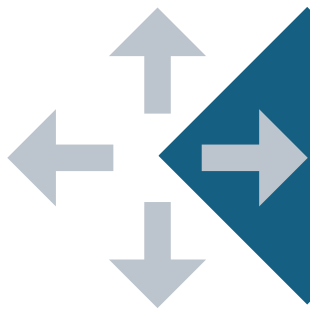


Do NOT withdraw your appeal until you have the resolution in writing and signed by DRS

WHAT TO DO IF YOU LOSE YOUR APPEAL



Reapply for services at any time



Ask to be re-scored again due to a disability, medical, or family/caregiving status change

HOW TO GET HELP

Legal Council for Health Justice

- Children and youth only
- Income requirement < 400% Federal Poverty Level
- Referral from Lurie Children's or Comer Children's is needed in most cases

Equip for Equality

- All ages
- Typically can only provide basic guidance

Legal Aid

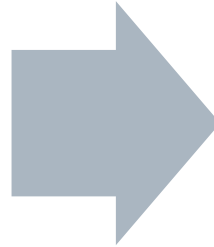
- Lower Income
- Some have minimal experience with this type of appeal

MEDICALLY FRAGILE TECHNOLOGY DEPENDENT WAIVER APPEALS

TWO TOPICS FOR MFTD APPEALS

DENIAL

- Applied for the MFTD Waiver and did not score enough points on the Level of Care (LOC) Tool to qualify



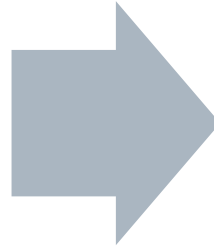
CUT

- Individuals who have had their nursing hours cut or eliminated

CASES THAT MAY BE ABLE TO BE RESOLVED WITHOUT APPEAL

Change in Medical Status

- Request temporary extra hours
- Request re-evaluation
- Requires new Physician Letter



Change in Family Status (caregiver unavailable, divorce, child newly attending school)

- Request temporary extra hours if temporary
- Request re-evaluation
- Usually requires new Physician Letter

MFTD THINGS THAT CANNOT BE APPEALED

Over age 21 and newly applying

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Child under 21 with significant income, assets, or certain types of trusts

A light blue downward-pointing arrow with a white outline, indicating a flow from the second box to the third.

If you don't live in Illinois or do not have citizenship or legal status

LEVEL OF CARE TOOL (ENTERING MFTD WAIVER ONLY)

1. TECHNOLOGY NEEDS	Points	Previous	Current	#	Freq.*	Justification
A. Ventilator Support						
Dependent (16 or more hrs/day)	50					
Intermittent (less than 16 hrs/day)	45					
B. CPAP, BIPAP, NON-INVASIVE VENTILATOR						
Via tracheotomy (non-ventilator)	45					
Via mask, pneumo-belt or sip and puff ventilator	35					
C. Tracheotomy	43					
D. Nasal Stents	20					
E. Oxygen Therapy						
Continuous, unstable (12 or more hrs/day)	35					
Intermittent - based on O2 sats (less than 12 hrs/day)	20					
Continuous, stable (6 or more continuous hrs/day)	15					
F. IV Infusion	40					
G. NG Tube						
Continuous (6 or more continuous hrs/day)	40					
Bolus	25					
H. G-Tube and/or J-Tube						
Continuous feeding with reflux (6+ continuous hrs/day)	35					
Continuous feeding (6+ continuous hrs/day)	15					
Bolus feeding with reflux	10					
Bolus feeding	5					

2. CARE NEEDS	Points	Previous	Current	#	Freq.*	Justification
Less than 3 times per day	2					
N. Hospitalization/ER Visits/Emergency Hours	5					
SUBTOTAL CARE NEEDS						If Care Needs or Technology Needs Score is 0, client is not eligible for MFTD Waiver.
SUBTOTAL TECHNOLOGY NEEDS						
TOTAL LOC SCORE						If total score is less than 50, client is not eligible for MFTD Waiver.
Care Coordinator's Initials _____						

*FREQUENCY KEY: H = hour, D = daily, W = weekly, O = other

2. CARE NEEDS	Points	Previous	Current	#	Freq.*	Justification
A. Suctioning: Child can do? Yes ☐						
Child can do? No ☐						
Daily	3					
B. Tracheotomy Care: Child can do? Yes ☐						
Child can do? No ☐	5					
C. Vital Signs Instability	3					
D. Special Treatments:						
4 or more times per day	8					
3 times per day	6					
2 times per day	4					
Once per day	2					
E. Medication:						
Complex (7 or more routine medications)	8					
Moderate (3-6 routine medications)	4					
Simple (1-2 routine medications)	2					
F. IV/Total Parenteral Nutrition						
Continuous (16 or more continuous hrs/day)	8					
8-15 hours per day	6					
4-7 hours per day	4					
Less than 4 hours per day	2					
G. NG/GT Feeding						
Continuous (6 or more continuous hrs/day)	5					
Every 2 hours	4					
Every 3 hours	3					
Every 4 or more hours	2					
H. Aspiration Precautions with NG/GT Feeding	2					
I. Specialized I/O Monitoring	5					
J. Intermittent Catheterization: Child can do? Yes ☐						
Child can do? No ☐	4					
K. Seizure Precautions Required	1					
L. Seizures Requiring Intervention						
Daily	3					
Less than daily but more than once per month	2					
Less frequently than once per month	1					
M. Dressings, Sterile						
3 times per day or more	3					

3. HISTORY OF HOSPITAL/ EMERGENCY ROOM VISITS AND EMERGENCY HOURS

MOST COMMON REASON FOR DENIALS: PHYSICIAN LETTER

Does not specify all the required information to be scored correctly on the LOC Tool

- All diagnoses
- All medications
- All procedures
- Feeding method, schedule, reflux or not, aspiration or not
- Technologies and when/how used
- Skilled nursing and monitoring
- Hit all areas asked in LOC tool
- Use AI with a prompt connected to the LOC tool to help you!

Did not request a specific number of hours

- Don't let the state decide your hours!
- Parents of kids under 21 cannot be compelled to provide care – hours are based on medical necessary
- Determine the number of hours you can provide weekly and request the remainder, explaining specifically why they are needed (school, during sleep, during work) – overestimate slightly

Requested 24/7 care

- This is the same as requesting NO hours – the state will decide your hours
- Request a specific number of hours per week and justify why they are needed medically

OTHER REASONS FOR DENIALS OR CUTS

Lack of nursing records or poor charting

- Make sure your Plan of Care is correct and updated
- Make sure nurses are charting everything they are doing

Child has not been hospitalized or been to the ER this year

- In your Physician Letter or appeal, include a list of what would have been hospital or ER visits if you did not have nursing

Child is not using awarded nursing hours

- Legally, it is the responsibility of the state to arrange and make sure hours are being provided
- Show evidence you have tried to find nurses (ads, multiple agencies, staffing support team, etc.)

SPECIAL RULES FOR THOSE UNDER 21 (EPSDT)

Nursing and personal care hours provided by Medicaid are ONLY based on Medical Necessity

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If there has not been an improvement in medical status, hours cannot be cut

A light blue downward-pointing arrow indicating a flow from the second box to the third.

Parents cannot be compelled to provide care but may choose to do so

PEER-TO-PEER OPTION

DSCC can arrange a conversation between your physician and the state's physician

Can be logistically challenging to arrange

If it happens, it can be very effective in avoiding appeal

HOW TO FILE AN APPEAL – FILE WITHIN 10 DAYS TO KEEP SERVICES!

By mail: Illinois Department of Human Services, Fair Hearing Section, 69 W. Washington, 4th Floor, Chicago, Illinois 60602

Email: HFS.FairHearings@illinois.gov

Fax: (312) 793-2005

Call toll free 1-800-435-0774 (voice), (855) 418-4421, or 1-877-734-7429 (TTY)

Take your letter or appeal form to the local IDHS office.

Online through <https://abe.illinois.gov/abe/access/appeals>

HOW TO GET HELP

Division of Specialized Care for Children Appeal Tip Sheet

- DSCC is legally only able to give basic information

MFTD Waiver Families (families only)

- [Website](#)
- [Facebook](#)

Legal Aid

Legal Council for Health Justice

PUNS AND DD WAIVER APPEALS

NEWER PROTOCOL: SCREENING BEFORE PUNS LIST

Most individuals are now being screened for a “reasonable basis to suspect a developmental disability” before being placed on the PUNS waiting list

This ensures that most individuals will qualify for the waiver when they are pulled from PUNS

As a result, most appeals going forward will be for getting ON the PUNS list and not the waiver itself

Some individuals who have been on the PUNS list for a long time may not have been screened comprehensively

COMMON DD-RELATED APPEALS

Denied
access to
PUNS list

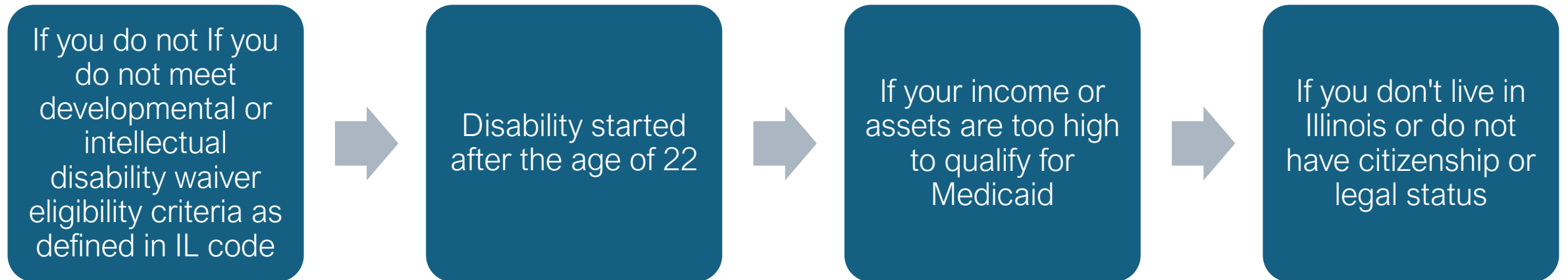


Denied Crisis
Spot on
Waiver



Denied Adult
DD Waiver

WHAT YOU CANNOT APPEAL



MOST COMMON PROBLEM: LACK OF DOCUMENTATION

IEPs from age 3 to 22

Testing and evaluations
from your physician,
neuropsychologist,
psychiatrist, or other
evaluator

IQ test results, multiple
needed especially if
they vary widely

Therapist reports and
evaluations and
behavior plans

Documented safety
issues

Reports of justice or
police involvement

Hospitalization and ER
reports, specifically
relating to behavior or
psychiatric needs

Any other
documentation relating
to your disability or
medical condition

DD WAIVER AND PUNS APPEALS

INFORMAL

- Informal appeal with a supervisor at the Independent Service Coordination Agency



DIVISION

- Next level will be to initiate an appeal with the Division of Developmental Disabilities



STATE HEARING

- Can then appeal using a state hearing if desired

APPEALS PROCESS

DDD Appeal

- File a written request with your ISC within 10 days of receiving your notice that you want to appeal
- [Guidance is here](#)
- Your ISC will help you to complete the appeal packet, including [DDD Appeal Form IL444-0171](#) and other requested documents
- The appeal packet must be submitted within 45 calendar days to DHS.DDDAppeals@illinois.gov
- The Division has 30 working days to complete an informal review of the appeal case and 10 working days to notify individual/family

Administrative Hearing with HFS

- If you disagree with the determination by DDD, you can request an administrative hearing within 10 days
- Submit your intent to appeal to:
 - By mail: Illinois Department of Human Services. Fair Hearing Section, 69 W. Washington, 4th Floor, Chicago, Illinois 60602
 - Email: HFS.FairHearings@illinois.gov
 - Fax: (312) 793-2005
 - Call toll free 1-800-435-0774 (voice), (855) 418-4421, or 1-877-734-7429 (TTY)
 - Take your letter or appeal form to the local IDHS office
 - Online: <https://abe.illinois.gov/abe/access/appeals>

YOUR FIRST CALL!

The Arc of Illinois Family Advocate Program and Family Support Network

- Can assist with getting on the PUNS list
- Can assist with crisis spots
- Can assist with information to help you appeal

Call 708-331-7370 or 815-464-1832 ext. 1032

Visit [Family Advocate Program Website](#)

THE HEARING PROCESS

SEE LAST YEAR'S PRESENTATION ON FAIR HEARINGS

Steve Scheuer's presentation has lots of great visuals on how to appeal and the hearing process

https://www.thearcofil.org/wp-content/uploads/2025/09/DHS-Medicaid-Appeals_The-Arc-of-IL-Fall-Symposium-2025.pdf

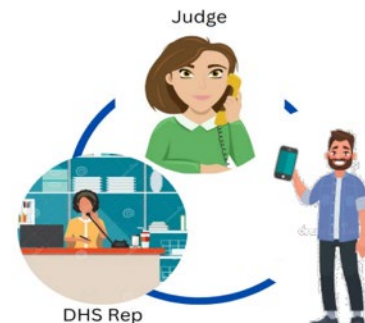
After filing the appeal

Hearing day

The FCRC rep will likely call before the hearing for a final pre-hearing conference. Coach the beneficiary to direct any calls to their representative.

Conversations with the judge usually will be recorded.

If you do not get a call within 1 hour after your hearing start time, email dhs.bahcoordinator@illinois.gov to let them know you're ready and waiting.



ADMINISTRATIVE HEARING WITH HFS OR DHS

You will receive information (evidence) from your waiver/program at least three days before the hearing

Hearing is usually over the phone with an Impartial Hearing Officer

- Your waiver/program will present their case, and you will present your case
- You can present documents and witnesses
- You can bring someone to help you, including a lawyer or advocate
- You can bring witnesses to testify on your behalf, like a doctor, nurse, or personal assistant

You will receive a decision within about 60 days

If you disagree with the decision, you can go to court or reapply for the program (in some cases)

DOCUMENTS THAT CAN HELP

All records from any hospital stays, especially the Discharge Summary for each hospitalization

Documentation from each ER visit and Urgent Care visit

Physician's report from every primary care and specialist visit in at least the past 6-12 months

Other medical reports from other types of medical practitioners, such as therapists, behavioral, psychologists

Lab reports for the past 6-12 months

Reports from any medical studies that have been performed in the past year (sleep studies, imaging, testing, etc.)

Surgical reports from any procedures or surgeries

A letter of support from the individual's prescribing physician

Letter(s) of support from the individual's palliative care, hospice, or complex care physician or nurse

Letter(s) of support from the individual's specialists

DOCUMENTS THAT CAN HELP CONTINUED

Relevant school reports, IEP, or 504 plan

Letter(s) from CAREGIVER physician/therapist/psychologist outlining physical or psychological problems

Current Plan of Care, Behavioral Plans, etc.

Current task sheets, medication sheets, flow sheets, and nursing logs

Current nursing progress notes, at least one week, and up to 6-12 months

Current nursing summaries, if your nurses write a daily end-of-shift communication, for the past 6-12 months

Selected nursing notes or summaries to highlight specific medical events that occurred

Copies of your nursing or personal assistant schedule

Copies of your work schedules and other obligations

MEDICAID, MANAGED CARE, AND INSURANCE DENIALS

WHAT FUNDERS ARE WE TALKING ABOUT?

Medicaid Fee-for-Service

- “Straight” Medicaid through the state without a plan

Insurance

- Private insurance companies
- Through employment, unions, or the ACA Marketplace

Medicaid Managed Care Organization (MCOs)

- Plans for those on Medicaid
- Including Aetna, Blue Cross Community, County Care, Meridian, and Molina

WHAT ARE YOU APPEALING?

When an item, device, supply, medicine, or piece of equipment is denied

When a service, such as a therapy, doctor visit, medical procedure, or hospital stay, is denied

MEDICAID APPEALS (FEE-FOR-SERVICE MEDICAID)

You can appeal almost ANY Medicaid decision

- Therapy or other service not approved
- Medical equipment or supply not approved
- Medications not approved
- Cuts to hours or services

Start with a Letter of Medical Necessity from your physician

- For those under 21, include a statement that EPSDT requires the state to cover any physician-mandated treatment for a diagnosed condition. Make sure you indicate what the diagnosis is and what the treatment is.
- "Treatment" has a wide meaning
 - Diapers are a "treatment" for incontinence
 - Home nursing is a "treatment" for medical technology dependence

Other Info

- Your doctor may be able to do a Peer-to-Peer review without having to appeal
- The state may require more information for certain items/services
- Expedited appeals are available
- Appeal process is identical to the hearing process in the previous section

MEDICAID MCO APPEALS: AETNA, BCBS COMMUNITY, COUNTY CARE, MERIDIAN, MOLINA

Each plan has its own process – see this guidance: [MCO Appeals Info](#) (may change in January 2027)

Start with an informal appeal including additional information and a Letter of Medical Necessity

- Use your case manager, if you have one

You can file a Grievance (complaint) or an Appeal (for a denial of service/item)

Appeal within 60 days to the MCO

Historically, most MCO appeals don't go anywhere. If you do not have success with the MCO, appeal for a State Hearing within 10 days of receiving notice of your MCO appeal to keep your services intact

State Hearing appeal process is the same as in the Hearings Process information

PRIVATE INSURANCE: FIRST LEVEL APPEALS

Start with calling and explaining the issue, as many things can be resolved over the phone

Extremely common due to:

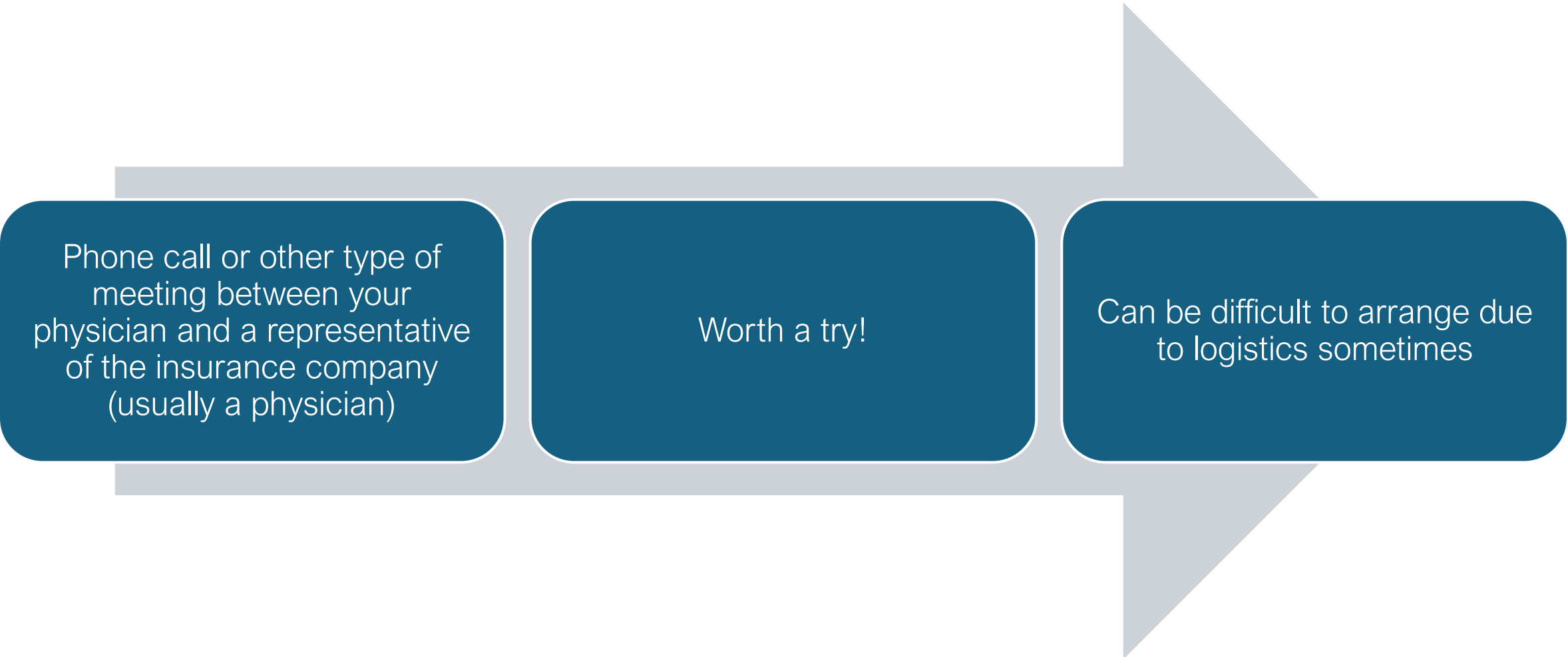
- Missing or incorrect information
- Improper coding
- Intentional denials to minimize costs
- Incorrect application of policy, state, or federal rules
- Surprise medical bill

Send a written appeal, including a Letter of Medical Necessity and other information, such as medical records

Use your case manager if you have one

May require multiple phone calls or letters or a combination of the two

PRIVATE INSURANCE: PEER-TO-PEER (OPTIONAL)



Phone call or other type of meeting between your physician and a representative of the insurance company (usually a physician)

Worth a try!

Can be difficult to arrange due to logistics sometimes

PRIVATE INSURANCE: EXTERNAL APPEAL

Appeal with an individual, usually a physician, with no relationship to the insurance company

Should be a neutral third party

Used to use practicing doctors but has now become a profit mill

The physician doing the appeal may not have any experience in the specialty requested

Many of these physicians do not have experience practicing or no longer practice

INSURANCE APPEALS: OTHER OPTIONS

Ask your Human Resources Department to overrule the decision

- They pay the insurance company and have power over them
- This is especially true for self-funded plans from large employers

File a complaint or ask for help from the Attorney General or Department of Insurance

- Attorney General Healthcare Bureau or (877) 305-5145
- Department of Insurance or (877) 527-9431

Go to Court

- With a lawyer!

TIPS FOR SUCCESS

Know your timelines!

Always get the name, phone number, and other information of the person you spoke to

Always include all the relevant information: name, age, ID numbers, what you are appealing, diagnoses, brief medical history, and rationale

Request a copy of the rationale for denial and specific policy used to make the decision

You can ask for the name/qualifications of the person making the decision, but usually they won't tell you (and they don't have to despite what social media says)

MORE TIPS FOR SUCCESS

Explain how the item/service will prevent complications/death and save money in the long run

Always get a Letter of Medical Necessity from your physician (even if you or AI writes it and they sign it)

Cite medical studies and other documentation proving the value of the service/item

Cite policy documents, state/federal laws, or any other rules that support coverage of your item/service

Never take the first
no as your final
answer

FINAL WORDS OF WISDOM...

MY CONTACT INFORMATION



779-254-9158
815-464-1832 ext. 1017
866-931-1110
Spanish: 800-588-7002
Language Line for other languages



susan@thearcofil.org



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