Vermont Department of Financial Regulation
Healthcare External Appeal

If you have had health care services which have been denied and you think they should be covered, talk with your doctor or healthcare provider or call your health plan to get help understanding the plan's decision. If you are still not satisfied, tell your plan you want to file a complaint (grievance). You must complete the plan's internal process. If you are still unhappy with your plan's decision, you may have the right to get an independent review of that decision.

Contact Consumer Services at 800-964-1784 or 802-828-3302 as soon as possible to find out if you qualify for an external appear with the Department of Financial Regulation. Your medical information will be kept confidential.

You must request an external appeal within 120 days or 4 months (whichever is longer) of receiving the final denial letter from your insurer.

- Healthcare External Appeal Form

To qualify for an independent external appeal, the insurer must have denied coverage for one of the following reasons:

- The service is not medically necessary, or
- The selection of a health care provider is limited in a way that is not allowed by your contract or by law, or
- The service is considered to be experimental, investigational, or an "off-label" use of a drug, or
- A medically based decision was made that your condition was "pre-existing", and
- Was a covered benefit under you plan.

If it appears that you qualify, you may complete the attached application or ask us to send you an application. There is a $25 filing fee that may be waived. We will collect documents from you and the insurer and submit them to the Independent Review Organization (IRO). Decisions by the IRO are made within 30 days of receiving all information.