Medicare Appeal: Step-by-Step Checklist

Denials get overturned more often than you'd think — companion to "How to appeal a Medicare denial."

First 48 hours after a denial

- [ ] Find the denial in writing (Medicare Summary Notice or plan letter) — note the DEADLINE printed on it
- [ ] Identify the reason code — appeals answer the specific reason, not the general situation
- [ ] Call the provider's billing office: many denials are coding errors fixed with a resubmission

Building the appeal

- [ ] Ask the doctor for a letter of medical necessity that addresses the denial reason directly
- [ ] Gather supporting records: relevant visit notes, test results, prior treatments tried
- [ ] Write a short cover letter: what was denied, why it's medically necessary, what you're asking for
- [ ] Keep copies of EVERYTHING; send trackable mail or file online

Know the ladder (Original Medicare)

Level	Who reviews	Typical deadline to file
1. Redetermination	Medicare contractor	120 days from denial
2. Reconsideration	Independent reviewer (QIC)	180 days from Level 1 decision
3. ALJ hearing	Administrative law judge	60 days (minimum dollar amount applies)
4–5. Council / Federal court	Appeals Council, then court	60 days each

Medicare Advantage and Part D plans have their own (faster) first steps — check the plan letter. If care is ending NOW (e.g., rehab discharge), request a FAST appeal through your state's QIO — you may have as little as 48 hours, and care often continues during review.

Free help

Your State Health Insurance Assistance Program (SHIP) will help you file at no cost. Don't do this alone — appeal success rates rise sharply with help.