

Medicare Minute Script – May 2026

Original Medicare and Medicare Advantage Appeals

An appeal is a formal request for review of a decision made by Original Medicare or your Medicare Advantage or Part D plan. If you were denied coverage or authorization for a health service or item, you may appeal the decision. Let's talk about how you can do this.

Point 1: Take action if you are denied coverage for a health care service or item.

Before you start your appeal, make sure you read all the letters and notices sent by Medicare or your plan. Call Medicare or your private plan to learn why they're denying your coverage, if the reason wasn't given or if you don't understand it. This will help you address the reason for denial in your appeal letter. You can strengthen your appeal by including a letter of support from your doctor that explains why you need the service or item. There is more than one level of appeal, and you have the right to continue appealing if you are not successful at the first level. Make sure to file each appeal in a timely manner, or your appeal may not be considered. If there is a reason you can't submit your appeal within the timeframe, you may be eligible for an extension. Keep in mind that an appeal is different from a grievance, which is a formal complaint that you file with your plan.

Point 2: Begin an appeal for an Original Medicare denial.

To find out if Original Medicare has covered or denied the health care services you have received, check your Medicare Summary Notice, or MSN. The MSN is a summary of health care services and items you have received during the previous six months. The MSN is not a bill. MSNs contain information about charges billed to Medicare, the amount that Medicare paid, and the amount you are responsible for. If your MSN says that Medicare did not pay for a service, and you think it should, call your doctor before appealing to make sure that there was not a billing error. Then, start your appeal by following the appeal instructions listed on your MSN. Next, send your appeal to the Medicare Administrative Contractor, or MAC, within 120 days of the date on your MSN. The MAC's name and address are listed on your MSN. The MAC should make a decision within 60 days. If your appeal is successful, your service or item will be covered. If your appeal is denied, you can move on to the next level by following the instructions on the MAC denial notice.

Point 3: Begin a pre-service or post-service appeal for a Medicare Advantage plan.

If your plan denies coverage or authorization for a health service or item before you receive it, you can appeal to ask the plan to reconsider its decision. Before you start your appeal, you will need to get an official written decision from your plan, called a Notice of Denial of Medical Coverage. You can start your appeal by following the instructions on the Notice of Denial of Medical Coverage and filing your appeal within 60 days of the date on this notice. You will need to send a letter to your plan explaining why you need the service or item. Your plan should make a decision within 30 days.

This process looks a little different if your plan denies coverage for a service or item that you have already received. You should receive a written notice from your plan stating that it is not covering your health service or item. This can either be an Explanation of Benefits, called an EOB, or a Notice of Denial of Payment. This is

not a bill. Start your appeal by following the instructions on the notice you received from your plan, and file the appeal within 60 days of the date on the notice. Your plan should make a decision within 60 days. If your appeal is successful, your service or item will be covered. If your appeal is denied, you can move on to further levels of appeal by following instructions on the denial notice.

Point 4: Look out for recent fraud schemes.

It’s important to stay updated about Medicare fraud because the schemes are always changing. Recently, skin substitutes have become the center of recent Medicare fraud scheme. Skin substitutes are a type of special wound care for wounds that do not heal. In some cases, a health care provider may give you skin substitutes when they are not necessary, or they may give you more than you need. Beware of these red flags:

- Claims on your Medicare statements for skin substitutes that you did not receive, request, or need.
- You are provided or billed for medically unnecessary treatments or excessive amounts of product.
- Your loved one in hospice care is offered complicated wound care from a sales representative. Patients nearing the end of their lives can be vulnerable to skin substitute fraud.

If you think you have experienced potential Medicare fraud, it’s important to contact your Senior Medicare Patrol, or SMP, for help reporting the incident.

Take Action:

1. Contact your State Health Insurance Assistance Program (SHIP) for counseling around appeals.
2. Contact Medicare or your Medicare Advantage plan for more information regarding their denial.
3. Contact your health care provider to request a letter from your doctor in support of your appeal.
4. Contact your Senior Medicare Patrol (SMP) if you have experienced Medicare fraud, abuse, or errors.

Local SHIP Contact Information	Local SMP Contact Information
<p>SHIP toll-free: 800-247-4422 SHIP email: idahoshiba@doi.idaho.gov SHIP website: shiba.idaho.gov</p> <p>To find a SHIP in another state: Call 877-839-2675 and say “Medicare” when prompted or visit www.shiphelp.org.</p>	<p>SMP toll-free: 800-247-4422 SMP email: idahoshiba@doi.idaho.gov SMP website: Medicare Fraud Prevention - Idaho Commission on Aging</p> <p>To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org.</p>

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