Bottom Line
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## How to Get Your HMO to Pay Your Claims - Fast

**The larger the dollar amount of a claim filed with an HMO, the less likely the HMO is to pay for all--or even most--of it. No matter how frustrated you become with the HMO, don't give up. Managed-care companies count on most people to accept their decisions on claims, even if the companies are wrong.**

Here's how to get satisfaction on your medical claims.

Take an active role in the claims process. Unlike conventional--or indemnity--insurance policies, in which you personally file your claims, HMOs handle your claims for you. But if anything goes wrong--such as an HMO doctor's office neglecting to file the right forms or paperwork being improperly filled out--the HMO may deny the claim or delay payment for it. Helpful...

If your case is not routine: Ask the HMO to send you copies of all claims filed on your behalf. Review them, and promptly forward any missing information to the HMO's home office. Don't be afraid to telephone the claims examiner assigned to your case. Ask him/her to explain any decision you believe is unfair. If you're not satisfied, move up the chain of command and contact the examiner's supervisor.

With a complex medical problem that will require ongoing treatment: Establish a personal relationship with the case manager (who oversees the examiner) in charge of your paperwork. As a participant in the HMO, you have the right to see how the case manager has written up your problem--and what the HMO has recommended to your physician. When HMO employees know that you are taking an active role in your care, they are less likely to put up roadblocks.

Don't take the company's first no as the final answer. File an immediate appeal in writing.

Important: Carefully follow the complaint procedure outlined in your HMO handbook. Explain why you feel your benefits were wrongfully denied and clearly state what action you want your HMO to take. To protect your future legal rights, include the following sentence in every letter that you write to the HMO.

This appeal relates only to the denial of the benefits in question. It does not constitute, and shall in no way be deemed an admission, that I am limited in my fight to pursue a bad faith' remedy in state court.

Send your complaint letter by registered mail; return receipt requested--even if you are not required to do so. It's amazing how often HMOs claim they never received communications from patients so you should have proof to the contrary. Request a written response within 30 days. Set up a folder for all the paperwork on the grievance, and track on a calendar each step of the complaint process and when the HMO's responses are due.

Go straight to arbitration if you feel you are not getting a fair hearing. The internal appeal procedures set up by HMOs may not be as impartial as they seem. Some are biased in favor of the health plan because decision-makers in the appeals process are not likely to disagree with their fellow employees. The HMO's appeals process is not your only remedy. You also have the right to arbitration, an independent process conducted by third parties who are not usually beholden to the HMO. The sooner you can get your appeal heard in this setting, the better. Your HMO handbook lists the arbitration entity.

Get another medical opinion from doctors outside your HMO.

If your HMO doctor is reluctant to order a costly or experimental test or procedure that you're convinced you need, get a second, or even a third, opinion--even if you must pay for it out of your own pocket. If these outside doctors agree with you, ask them to write to the HMO on your behalf. The aim is to establish a written record that supports your case, should you later appeal.

Get documentation for using a nonaffiliated emergency room. Most people who seek care in an emergency room that is not affiliated with their HMO network do so when they are away from home. If you must visit a nonaffiliated emergency room, request a letter from the facility documenting that you had a real medical emergency. The letter should also state that you could not be transferred to a facility in the HMO network without endangering your health.

Make as much noise as possible. Start in your own company's human resources department with the person who is the official liaison with the HMO. Then contact local consumer hot lines and consumer affairs reporters at television stations and newspapers. Also complain to your local, state and federal elected officials--your mayor, state representatives and US senators. It's also wise to contact your Better Business Bureau and state attorney general.

Complain to the regulators. Contact the appropriate state regulatory agency--usually the Department of Insurance or the Department of Corporations--and ask about the procedures for filing a complaint against the HMO. Many states have waiting periods, but in some emergency cases a complaint may be filed and heard within 72 hours. Be sure to let your HMO know that you are contacting the state regulator.

If you are covered by both an HMO and Medicare, you can appeal to the Center for Health Dispute Resolution [1 Fishers Rd., Pittsford, New York 14534--(716)-586-1770]. If the Center for Health Dispute Resolution rules in your favor, you can then have the HMO provide appropriate care and treatment or have the HMO pay for the care and treatment you received in the interim. If you lose, you can file a complaint with the Administrative Law Justice division of Medicare.

Seek legal redress if necessary. If your claim is modest, file a claim in small-claims court. You don't need a lawyer, and the odds of winning are good. Your case will probably be heard within six months. If you have a major claim, look for a lawyer who specializes in  bad faith  cases against insurance companies and HMOs. You're best off hiring an attorney who works on a contingency basis. This means the attorney gets nothing if you lose but takes at least one-third of any amount you recover from the HMO.