Sample Appeal Letter – Indiana Medicaid (Home Health Hours)

[Your Full Name]
[Your Address]
[City, State ZIP Code]
[Your Telephone Number]
[Your Email Address]
[Date]

To:
Indiana Medicaid Appeals Department
[or Managed Care Entity, if applicable – e.g., Anthem, MDwise, Managed Health Services]
[Plan Address]
[City, State ZIP Code]

Re: Appeal for Denied or Reduced Home Health Services
Beneficiary: [Name of Beneficiary]
Medicaid ID #: [Medicaid Number]
Case/Reference #: [Authorization or Claim Number]
Date of Denial: [Date on Denial Letter]

To Whom It May Concern:

I am writing to appeal the denial/reduction of Medicaid-covered home health services for [beneficiary's full name]. We received a denial letter dated [insert date] indicating that [briefly restate reason for denial as listed].

After reviewing the applicable Indiana Health Coverage Programs (IHCP) policy and medical documentation, I believe the requested hours of home health services are both medically necessary and appropriate under Medicaid guidelines. [Insert service, e.g., "Skilled nursing and/or home health aide services"] are essential to support [beneficiary]'s health, safety, and daily functioning in the home setting.

This care is required in order for [him/her/them] to:
[select and/or modify as needed]

- Maintain medical stability and avoid unnecessary hospitalizations
- Receive timely support with skilled tasks such as [e.g., g-tube care, respiratory support, seizure monitoring, medication administration]

- Ensure safety due to [describe conditions such as mobility limitations, cognitive impairments, risk of aspiration, etc.]
- Reduce risk of institutional placement and allow [him/her/them] to remain safely at home with family
- Support developmental progress and consistent access to care in a familiar environment

Attached is a letter of medical necessity from [treating physician or home health agency] that details [Beneficiary]'s diagnoses, care needs, and the clinical rationale for the requested number of home health hours per week. I am also including [optional: nursing notes, prior authorizations, hospital discharge summaries, or therapy evaluations] as supporting documentation.

I respectfully request a full reconsideration of the decision and approval of the medically necessary hours of care as recommended by [Beneficiary]'s care team. These services are critical to [his/her/their] health and continued ability to remain at home with appropriate supports.

If you need additional information or documents, I can be reached at [phone number] or [email address].

Thank you for your time and attention to this matter.

Sincerely,
[Your Signature]
[Your Printed Name]

Optional Attachments:

- Physician's letter of medical necessity
- Home health agency care plan
- Recent hospital discharge summaries
- Relevant clinical notes or therapy reports
- IHCP policy excerpts if you want to cite them