



PRO SE / SELF-REPRESENTED GUIDE

Insurance Claim Denial Exhibit Guide

A practical guide to organizing evidence for appealing denied health, auto, home, and disability insurance claims.

Your insurance claim was denied. The denial letter probably cites policy language you have never read and uses codes that are hard to decipher. Under ERISA (29 U.S.C. section 1133), employer-sponsored health plans must give you specific written reasons for denying a claim and tell you how to appeal. The ACA (section 2719) requires health plans to offer external review by an independent reviewer. State insurance codes add more protections — many states have unfair claims settlement practices acts that let you file complaints with the state insurance commissioner. This guide walks you through what documents to gather and how to build your appeal.

Denial & Policy Documents

- Denial letter**
The letter explaining what was denied and why — look for the specific reason code and policy citation
- Insurance policy**
The relevant coverage sections of your policy — not the entire document, just the parts that apply
- Summary Plan Description**
For employer plans, the SPD explains your coverage in plain language
- Appeal rights notice**
The section of the denial letter explaining your appeal options and deadlines

Medical Evidence

- Treating physician's letter**
A letter from your doctor explaining why the treatment was medically necessary
- Medical records**
Records supporting the diagnosis and treatment plan
- Lab results and imaging**
Test results that support the medical necessity of the denied treatment
- Peer-reviewed literature**
Published medical studies supporting the treatment — especially useful for "experimental" denials

Property & Auto Evidence

- Photos of damage**
Dated photographs showing the damage from multiple angles
- Repair estimates**
Written estimates from licensed contractors or body shops — get at least two
- Independent appraisal**
An independent assessment if you disagree with the insurer's valuation
- Police or fire report**
Official reports documenting the incident that caused the claim

Correspondence

- Communications with adjuster**
Emails, letters, and notes from phone calls with your claims adjuster — include dates and names
- Claim submission records**
Proof of when you filed the claim and what you submitted
- Prior approval documentation**
If the treatment was pre-authorized, the approval letter or reference number

Appeal & Escalation

- Internal appeal letter**
Your written appeal addressing each reason in the denial letter point by point
- External review request**
The form to request independent external review (required for health plans under the ACA)
- State insurance commissioner complaint**
A complaint filed with your state's department of insurance if the insurer acted in bad faith
- Bad faith documentation**
Evidence of unreasonable delays, repeated denials without new reasons, or failure to investigate

COMMON MISTAKES TO AVOID

1. Not reading the specific policy language cited in the denial — the appeal must address those exact provisions
2. Missing the internal appeal deadline, which is typically 60 to 180 days depending on the plan type
3. Accepting the first denial without requesting an external review — independent reviewers overturn denials frequently
4. Sending a generic appeal letter instead of addressing each reason for denial specifically
5. Not requesting your complete claims file, which the insurer must provide under ERISA

ORGANIZATION TIPS

- Start with the denial letter and highlight the specific reason codes and policy sections cited
- Match each denial reason to a specific piece of evidence that contradicts it
- Create a side-by-side comparison: denial reason on the left, your evidence on the right
- Include a table of contents listing each exhibit so the reviewer can navigate your appeal quickly
- Keep a log of every phone call with the insurer: date, representative name, reference number, what was said

COURTROOM PREPARATION

- Most insurance appeals are decided on paper — your written submission is your only argument
- Address every denial reason specifically. If the denial cites 3 reasons, your appeal must respond to all 3.
- Under ERISA, the insurer must give you the specific reason for denial. A vague denial letter is itself a violation.
- Request your complete claims file before writing the appeal — you may discover the insurer ignored evidence you submitted
- If you exhaust internal appeals and external review, you may file a lawsuit. ERISA cases go to federal court; state-regulated plans go to state court.
- For health insurance denials: ask your doctor to write a letter specifically addressing the denial reason, not a generic "this is medically necessary" letter

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