

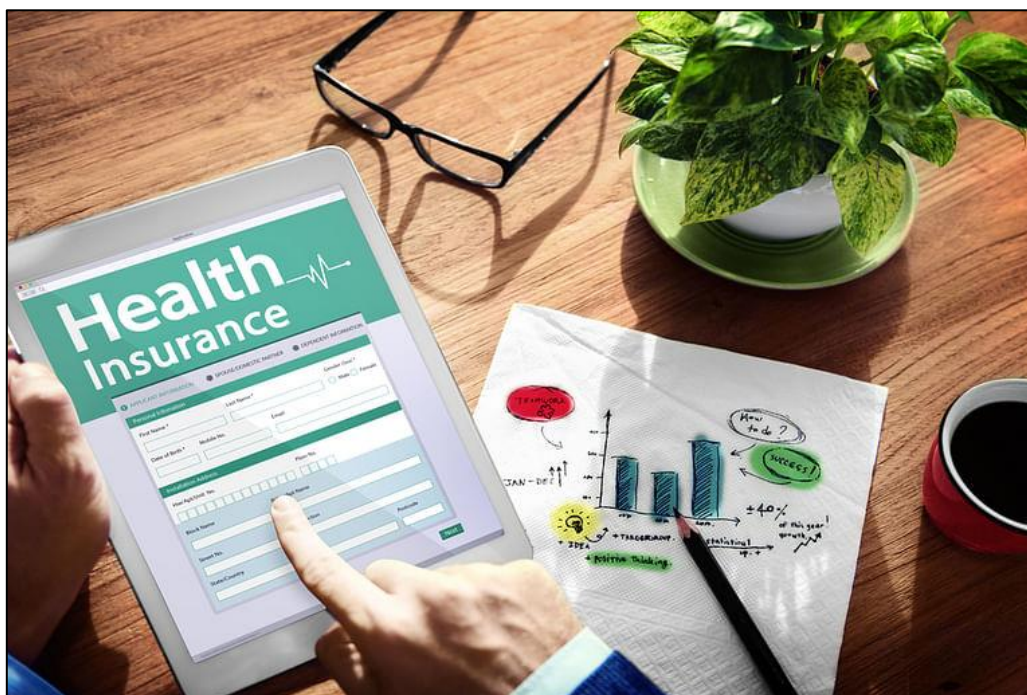
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Headline: - Denial Of Health Insurance Claims: Here Are The Reasons And Tips For Smooth Processing

[Denial Of Health Insurance Claims: Here Are The Reasons And Tips For Smooth Processing](#)

Dealing with denial of health insurance claims can be tough. Learn why it happens and how to make the process smooth



In a country where medical uncertainties are part of life's script, the sting of denied health insurance claims is an all-too-common woe.

Take the case of Arjun Mathur, a 45-year-old from Mumbai, who recently faced the brunt of this reality when his emergency appendectomy claimed more than just his appendix—it triggered a series of claim denials.

Here are the reasons why his claim got denied.

Coverage Limits Crossing: Mathur's policy had an annual limit of Rs 5 lakh and his medical bill breached this ceiling.

Deductible Dilemma: The Rs 20,000 deductible in Mathur's policy was unpaid at the time of surgery.

Non-disclosure: Mathur forgot to mention an old stomach issue when buying his insurance. Result, the non-disclosure bit him back.

Mathur faced some bumps when his [insurance](#) claims were denied. But he didn't give up. He fought back, sorted things out, and though he got a few financial scratches, he managed. What we learn from

Mathur's experience is that a bit of knowhow and a tough attitude can make a difference in the health insurance game.

So, it's important to understand your policy, be open about your health, and when life gets tricky, make sure your financial backup is good.

Take the case Raj Jawa, a 40-year-old IT professional from Delhi, who has a family health insurance policy covering him, his wife, and their two children. The policy had an annual coverage limit of Rs 4 lakh and a deductible of Rs 10,000.

Jawa's 10-year-old son, Rahul, needed urgent dental surgery after a mishap in the playground. The dental procedure cost Rs 25,000, and Jawa, thinking his insurance would cover it, went ahead with the treatment. To his surprise, Jawa's claim for Rahul's dental surgery was denied. The reasons were two-fold.

Exceeding the Annual Limit: The dental expenses, combined with other medical costs during the year, went beyond the policy's Rs 4 lakh annual coverage limit.

Deductible Not Cleared: Jawa had not met the Rs 10,000 deductible for the year, leading to the initial denial.

Says Jawa: "I was surprised by the denial, and swiftly appealed, submitting extra documents to highlight the urgency of my son's dental procedure and requesting for the reconsideration. To speed things up, I paid the outstanding Rs 10,000 deductible, ensuring compliance with the policy terms. I also contacted the dental hospital, negotiating a payment plan for the remaining uncovered amount. Thankfully, the hospital agreed to spread the payments over several months, lightening the financial load."

"In the aftermath, I delved into a comprehensive review of my policy with my insurance advisor. It became clear how crucial it is to be well-versed in annual limits and deductibles, especially when unexpected medical expenses hit. Following the appeal, deductible payment, and discussions with the hospital, my claim was reconsidered. While there were some out-of-pocket expenses, the insurance covered a substantial part of Rahul's dental surgery, providing relief in what could have been a more challenging situation," he adds.

Medical insurance claims can face denials due to various factors. Let us find out the reasons and how to prevent them.

Renewal And Disclosure: To avoid the rejection of [health insurance](#) claims, policyholders should be proactive in several key areas. First and foremost, staying vigilant about policy renewal dates is essential, as most health insurance plans require annual renewal.

Says Bhaskar Nerurkar, head – health administration team, Bajaj Allianz General Insurance: "Missing renewals can result in coverage lapses and subsequent claim rejections, although many insurers provide a 15-day grace period for renewal. Additionally, complete honesty regarding health information is crucial. It's imperative to disclose all pre-existing conditions and prior surgeries before opting for a new policy. Failing to disclose this information at the onset of the policy issuance can lead to claim rejection if it is found to be a pre-existing condition. At the same time, any new ailments acquired during the policy term must be informed to the insurer during renewal. Failing to do so can lead to complications or claim rejections, especially if some conditions have permanent exclusions."

Incomplete Or Inaccurate Information: When submitting a claim, it's also important to provide all the required details accurately.

Says Rakesh Goyal, director, Probus Insurance Broker: "Errors or omissions in your personal information, policy number, diagnosis, or treatment information can lead to claim denials. To prevent this, double-check all the information before submission."

Out-of-Network Providers: Insurance plans often have networks of preferred healthcare providers. If you receive care from a provider that is not in-network, your claim may be denied or result in higher out-of-pocket costs. So, always ensure your healthcare providers are within your insurance network. Whenever feasible, opt for treatment at preferred network hospitals, which offer cashless facilities, better rates, waived charges, and non-insurance benefits, thus simplifying the claim settlement process. Following these recommendations can help avoid claim rejection and also ensure a smooth and hassle-free health insurance claim experience.

Pre-Authorisation: Some medical treatments or procedures require prior approval or pre-authorisation from your insurance company. Failure to obtain this approval can result in claim denials. Adds Goyal: "To prevent this, be aware of pre-authorization requirements and follow the necessary steps, like obtaining a referral from your primary care physician if needed."

Policy Exclusions: Every insurance policy has specific terms and conditions, including what it covers and what it doesn't. Make sure you understand these exclusions. For instance, if your policy explicitly excludes elective cosmetic procedures, trying to claim expenses for such a treatment is likely to be denied.

Late Claim Submissions: Insurance companies have deadlines for submitting claims. Missing these deadlines can lead to claim denials. Be aware of your insurer's timeline and ensure that the claims are submitted promptly after receiving healthcare services.

Adds Nerurkar: "Promptly filing claims within the specified timelines, usually within 60-90 days from the date of discharge, is crucial. In case of genuine delay, it is recommended to communicate it to the insurer. Properly preparing the claim documents, including all necessary paperwork as requested by the insurer, is also critical."

Inadequate Documentation: Maintaining detailed records of your medical treatments, bills, and communication with healthcare providers and insurers is vital. Inadequate or missing documentation can hinder the processing of your claim. To avoid this, keep a thorough record and provide any requested information promptly.

For instance, let's say you have a medical insurance policy, and it explicitly states in the policy documentation that elective cosmetic procedures are not covered. You still decide to undergo cosmetic surgery, such as a facelift, for personal reasons. After the procedure, you submit a claim to your insurance company seeking reimbursement for the surgery expenses. In this scenario, the claim is likely to be denied because the policy clearly excludes coverage for elective cosmetic procedures.

Insurance policies have specific terms and conditions, and it's essential for policyholders to be aware of what is covered and what is not. Attempting to claim expenses for services that are explicitly excluded from the policy is a common reason for claim denials. To ensure you don't face such denials, always review your insurance policy thoroughly to understand its coverage limitations and exclusions.

If you have questions about what is covered, it's advisable to contact your insurance provider for clarification before undergoing any medical procedure. This way, you can make informed decisions about your healthcare expenses and prevent unnecessary claim denials.

Claims In Health Insurance

In health insurance, a claim refers to a formal request submitted by a policyholder to the insurance company asking for compensation for the medical bills incurred during the treatment at the medical facility.

Says Naval Goel, founder and CEO of PolicyX.com, an insurance web aggregator: "Claims are an important aspect of health insurance as they allow policyholders to receive financial benefits from the purchased insurance policy. It's important to understand the claim procedures and types of health insurance claims offered by the companies to ensure a smooth claim-filing process and to ensure that the claims are not rejected."

Types Of Health Insurance Claims

There are two types of claims in health insurance.

Cashless Claims: A cashless health insurance claim allows the policyholders to receive medical treatment without upfront payments at network hospitals. When admitted, policyholders inform the insurance company, submit a pre-authorisation form, and, upon approval, receive a letter. This letter facilitates cashless treatment, with the hospital settling approved expenses directly with the insurance company. Policyholders are spared upfront payments, offering financial ease during hospitalisation. However, understanding coverage limits and exclusions is crucial to ensure a seamless process.

Reimbursement Claims: Reimbursement claims in health insurance involve policyholders paying upfront for medical expenses at any hospital, but not limited to a network. After treatment, the policyholder submits the medical bills, reports, and receipts to the insurance company for reimbursement. The company reviews the documents, ensuring they align with the policy terms, and reimburses the approved amount.

While reimbursement offers flexibility in choosing hospitals, policyholders should be aware of coverage limits, exclusions, and the need for thorough documentation to facilitate a smooth reimbursement process.