**REQUEST FOR PLAN DOCUMENTS UNDER ERISA AND MHPAEA**

[Insert name of Psychiatrist or Plan Participant]

[Insert mailing address]

[Insert email or other contact information, if desired]

[Insert date]

[Insert name of appropriate contact at plan]

[Insert title]

[Insert mailing address]

**Re: Request for Plan Documents**

Dear Mr./Ms.\_\_\_\_\_\_\_\_\_\_\_\_:

[***Use if psychiatrist has been designated as Authorized Representative – Strike if not applicable***] I am writing on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is a plan participant in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [name of health plan] and has designated me as his [or her] authorized representative. I am writing to request copies of the plan documents listed below.

[***Use if letter is being sent directly by plan participant – Strike if not applicable***] As a participant in \_\_\_\_\_\_\_\_\_\_\_\_\_\_[name of health plan], I am writing to request copies of the plan documents listed below.

Pursuant to Section 104 of the Employee Retirement Income Security Act (ERISA) and 29 C.F.R. §2520.104b-1, I am entitled to receive copies of all instruments under which a health plan is established or operated. I am permitted to request copies of these materials at any time, regardless of whether a claim for health benefits has been submitted or if an adverse benefit determination has been made. ERISA mandates that this information be furnished to me within 30 days from the date of my request.

As requested, please send me copies of the following documents:

1. Information or documentation regarding the non-quantitative treatment limitations that apply to my health benefits, including any applicable medical necessity criteria, for both the medical/surgical and mental health and substance use disorder benefits available under my plan.

2. Information or documentation regarding the processes, strategies, evidentiary standards and other factors used in applying the non-quantitative treatment limitations and/or medical necessity criteria to the medical/surgical and mental health and substance use disorder benefits available under my plan.

3. Studies, schedules or similar documents containing information and data that serve as the basis for determining my health benefits, for both medical/surgical and mental health and substance use disorder benefits.

4. Any compliance analyses performed by my health plan for each of the non-quantitative treatment limitations that apply to my plan as well as any data and documentation used in its formation, including the compliance analyses required by the Mental Health and Addiction Equity Act of 2008.

Further, pursuant to The Mental Health Parity and Addiction Equity Act of 2008 and Final Rules (29 C.F.R. §2590.712(d)(1)) I am entitled to receive a copy of the medical necessity criteria used by the plan to make determinations regarding mental health and substance use disorder benefits offered under the plan. Therefore, I hereby request a copy of the medical necessity criteria used by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[health plan] to make determinations regarding mental health and substance use disorder benefits available under the plan for the treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [diagnosis or diagnoses]. In addition, please provide any information you have regarding the processes, strategies, evidentiary standards, and other factors used by the plan in applying the medical necessity criteria to mental health and substance use disorder benefits available under the plan.

Please forward the above documents to me at the following address no later than 30 days from the date of this letter:

[Insert name]

[Insert mailing address]

[Insert email address if you would like to receive a copy of the information electronically]

Thank you very much for your assistance in this matter.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

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