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HEALTH CARE LAW ADVISOR ALERT: WELL-DRAFTED ASSIGNMENT OF BENEFIT FORMS ARE CRITICAL WHEN FIGHTING ERISA CLAIM DENIALS

Most private health insurance coverage in the United States is employer-sponsored and governed by a federal law known as the Employment Retirement Income Security Act of 1974 (ERISA). Navigating an appeal of a benefit denial issued by an ERISA-governed health plan can be confusing. A quick review of federal regulations governing ERISA benefit denials, which can be found **here**, suggests how challenging it may be for health care providers to navigate the ERISA claims landscape successfully.

ERISA benefit denials are frequently written by a health insurer or third-party administrator (TPA) that is not the legal entity truly providing the health benefits to the patient. The legal entity providing the benefits—the health insurer**,** so to speak—is known as an "ERISA plan." When a health care provider obtains an assignment of its patient's benefits, those rights are against the ERISA plan, not necessarily the health insurer or TPA that may have written a benefit denial letter.

Health care providers can improve their chances of successfully recovering benefits from ERISA plans by ensuring that their Assignment of Benefit (AOB) forms are properly worded. AOB forms should fully authorize a provider to pursue all of its patient's appeal rights under ERISA. In addition, AOB forms should allow a health care provider to obtain full information about the ERISA plan's benefits, so that the provider can properly assess what benefits are available for various medical procedures. Absent appropriate AOB language, a provider's billing administrators may find themselves stymied when attempting to obtain the health benefits that both the provider and patient deserve. A review of AOB form language may be warranted to ensure that a health care provider has the best possible chance of recovering benefits from ERISA plans successfully.

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