

Project HEAL

Insurance Navigation Resources

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To apply for additional treatment access support, please visit www.theprojectheal.org/apply-for-support

HEALTH INSURANCE GLOSSARY

Terminology to Know

Affordable Care Act (ACA): the name of the health care reform law finalized in March 2010 that allowed people to purchase their own insurance as individuals, regardless of pre-existing conditions.

Allowed Amount: the negotiated rate your insurance company and provider have agreed upon for a particular service when completed within your insurance network. Your co-payments and co-insurance will be based on this amount.

Annual Limit: the amount an insurance plan will pay in total benefits over a year. Once you hit the cap, your policy will not pay again until the next year. The ACA prohibits annual limits on essential health benefits with the exception of grandfathered plans.

Benefits: the healthcare items or services covered under a health insurance plan.

Co-Payment: the amount you pay when you receive care. The co-payment amount is set by the insurance company not the doctor's office. This can be a percentage or flat rate amount. For example, the amount you pay may be \$30.00 each time with the insurance company picking up the rest of the cost.

Co-Insurance: the amount you pay after you meet the plan's deductible. For example, an 80/20 co-insurance rate means the insurance company pays 80 percent and you pay the remaining 20 percent. Co-Insurance usually does not start until you pay an amount equal to the deductible.

Deductible: the amount you pay out-of-pocket for medical expenses before your plan pays anything for the healthcare services you received. For example, if your deductible is \$1,000, your plan won't pay their portion for a covered service until you've hit your \$1,000 limit. Premiums do not count toward meeting your deductible.

Excluded Services: services your health insurance company or specific plan doesn't pay for.

Exclusive Provider Organization (EPO) Plan: this plan is similar to a HMO plan in that members are required to use network doctors. However, unlike a HMO plan, it is not necessary to select a PCP, you do need to contact a PCP for specialist referrals.



Explanation Of Benefits (EOB): an EOB is created after a claim payment has been processed by your health care plan. It explains the actions taken on a claim such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process. EOBs are available both as a paper copy and online.

Formulary or Drug List: a list of prescription drugs your health plan covers. Generic medications are typically covered in a formulary, whereas only some brand names are not.

Flexible Benefits Plan: a benefit program that gives employees a choice between cash, life insurance, vacations, retirement plans, and childcare. Although there are usually some requirements, flexible benefit plans offer a choice for the remaining benefits.

Health Insurance: a contract that requires your health insurer to pay for a portion (or all) of your healthcare services in exchange for a premium.

Health Insurance Marketplace: website where individuals, families, and businesses based in the US can research, compare and choose a health insurance plan that's best for them.

Health Maintenance Organization (HMO) Plan: in this plan, your Primary Care Provider (PCP) is who you want to reach out to first. If you need care outside of what your PCP can offer, they will refer you to another provider.

Health Plan Categories:

- Bronze Plan – Estimated to cover 60 percent of medical bills, leaving the insured member to pay the remaining 40 percent up to established out-of-pocket maximum.
- Silver Plan – Estimated to cover 70 percent of medical bills up to established out-of-pocket maximum.
- Gold Plan – Covers 80 percent of medical bills up to established out-of-pocket maximum.
- Platinum Plan – Estimated to cover 90 percent of medical bills up to established out-of-pocket maximum.

In-Network or Preferred Provider: a physician, healthcare provider or healthcare facility that has a contract with your plan to provide their members services at a lower cost to the insurance company.

Medical Necessity Criteria: standards used by health plans to decide whether treatments or health care supplies recommended by your mental health provider are reasonable, necessary and appropriate. If the health plan decides the treatment meets these standards then the requested care is considered medically necessary.



Network: the contract between your insurance and your healthcare provider.

Out-of-Network: a physician, healthcare provider or healthcare facility that does not have a contract with your plan. Using healthcare services that are not covered in your plan will greatly increase the amount you have to pay.

Out-of-Pocket Limit: the amount you pay out of your own pocket when treatment or service is not covered by your plan. For example, some plans do not cover laboratory tests, x-rays, or medication.

Out-of-Pocket Maximum: the highest amount of money a person will have to pay during their plan period. It includes the money spent within the deductible amount, co-insurance, co-pays. Once you reach this limit, the insurance company will pay 100% of the allowable amount of costs for all covered benefits. Out-of-pocket maximum is higher than your deductible and does not include medication costs or services that are listed as excluded within your plan language. Today most plans have separate medication and medical out-of-pocket maximums.

Point of Service (POS) Plans: this kind of plan will allow you to pay less if you use in-network doctors or services.

Preauthorization (aka: prior-authorization or pre-approval): an insurance plan may require prior approval for certain services, drugs, or equipment to consider any charges.

Preauthorization is not a guarantee that the insurance plan will cover the cost of the service, however, this is generally the first step for those requiring services that are not currently in-network with their insurance plan.

Preferred Provider Organization (PPO) Plan: this plan provides the patient access to a network of preferred providers, also known as in-network doctors. This means the list of doctors have been approved by your health insurance plan. Your out-of-pocket expenses will be less if you use a provider within the plan, however if you use a doctor that is out of network, you will still receive some reimbursement. This type of plan is typically more expensive but they include a larger network of doctors, including specialty doctors.

Premium: the amount you pay monthly, quarterly or yearly for your health insurance plan. If you have insurance through the workplace, your employer may pay a portion of your premium on your behalf as part of your employee benefit package.

Provider: a physician, healthcare provider or healthcare facility licensed, certified or accredited as required by law.



Specialist: this type of provider focuses on a specific area of medicine or illness. Some specialists may not be in-network with your plan.

Utilization review (or utilization management): process used by insurers to decide whether the requested mental health care is medically necessary, efficient and in line with accepted medical practice. In line with accepted medical practice means that the mental health treatment or service is proven to be effective based on scientific evidence.



EATING DISORDER INSURANCE Q&A

Q: What do all the different payment terms mean?

A: A few different factors go into paying for treatment. Most insurance plans have a premium, which is a monthly fee that the patient pays for their insurance plan. Many patients also have an insurance deductible, which is a set amount that the patient has to pay out-of-pocket before their insurance benefits kick in. After the deductible is met, patients are typically charged a co-pay (a set dollar amount per visit) or co-insurance (a set percentage of the total cost of the visit) each time they receive treatment. Many insurance plans also have an out-of-pocket maximum, which is a cap on the amount that the patient pays per year in co-pays and/or co-insurance.

Q: What are common reasons an insurance company denies coverage of eating disorder treatment or payment for services?

A: While there are many reasons a health insurance plan may deny coverage of eating disorder treatment or payment for such services, there are some common reasons you may be experiencing depending on your plan and the services you are seeking coverage for.

- Level of care (or services) deemed not “medically necessary”
 - Not eligible for coverage of services requested under your health plan
 - Failure to attempt treatment a lower level of care prior to requesting coverage for a higher level of care
 - Not eligible for coverage of services requested until trying x services (generally preferred in-network option)
 - Eating disorders are not an explicitly named “row” of issues covered on your health plan’s Explanation of Benefits (EOB) and therefore quickly dismissed without exploration by the payor
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Q: What ED treatment do Medicare and Medicaid cover, and why is it so limited?

A: Currently, most Medicare and Medicaid plans limit their coverage of eating disorder treatment to inpatient (hospital-based) and outpatient programs. It’s important, however, to keep in mind that every plan is different and that you should contact your insurance company to verify your benefits and coverage options.



A cont'd: The coverage of eating disorder treatment for those with Medicare and Medicaid is so limited because of how those programs have been designed. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally requires group health plans and health insurance payors to provide mental health or substance use disorder benefits to have equal benefit coverage of mental health diagnoses as medical diagnoses. However, because medical issues are treated either in a hospital or via office visits, the MHPAEA limits mental health coverage to the same treatment options, i.e. inpatient or outpatient. This then excludes any other levels of care that are often required for mental health conditions like eating disorders, including residential, most partial hospitalization programs (unless they are hospital-based), and most intensive outpatient programs (unless they are hospital-based).

Q: My insurance plan does not have any in-network outpatient specialized eating disorder therapists. Is there anything I can do to avoid paying a provider out-of-pocket?

A: Depending on the specific insurance plan, there are likely steps you can take to avoid taking on out-of-pocket costs. Specifically, you will want to follow up with a representative from your insurance company who can let you know whether or not your plan has an option to coordinate a single case agreement (SCA) or special coverage agreements. An SCA is a contract between an insurance company and an out-of-network health care provider for a specific patient that enables the patient to receive in-network coverage for an out-of-network provider for an established period of time.

Q: Overview of your rights with insurance companies?

A: [Patient's Bill of Rights](#) (2010)

Q: What is a utilization review?

A: A utilization review occurs when your health insurance company reviews a patient's request for treatment. During the utilization review, your health insurance company will decide whether they are able to cover the requested treatment.

Q: What are my options if my health insurance denied pre-authorization for my treatment or covering treatment services already rendered?

A: If your insurance company denies coverage for treatment services, you can submit an appeal...



A con'td: or your health insurance to review their decision. The appeal process differs by health insurance company; you can find more information on your health insurance's appeal process on their website. You can find more information about health insurance appeals [here](#) and [here](#). If your appeal is denied, you may want to resubmit. If you believe the denial was unfair to the point of being illegal, you should consult an attorney ([see list of legal practices that might be able to help](#)).

Q: What is the difference between Medicare and Medicaid?

A: Medicaid is a state-run health insurance for people whose income is below a certain level. Medicare is a federally-run health insurance for people above the age of 65 and who have certain qualifying disabilities. Medicaid coverage can vary by state and managed Medicaid plan, while Medicare is accepted in many states regardless of the plan.

Q: How do I submit a Single Case Agreement (SCA)?

A: The process of coordinating a SCA varies by insurance provider. However, since SCAs involve both your insurance and your treatment provider, it is recommended to be in touch with both parties throughout the process so that everyone is on the same page.

Q: Will my health insurance cover treatment expenses from a facility located in a state different from where I live?

A: It depends on your insurance provider. Most insurance providers' websites have a list of all of their in-network treatment providers, so it's important to check there before your first treatment appointment.

Q: What is the Mental Health Parity Act (MHPA)?

A: The [Mental Health Parity Act](#) is a federal law that was signed in 2008. This law requires that insurance companies provide equivalent coverage for mental health and substance use services that they would for other health services. This law paved the way for in-network mental health coverage. However, it is underenforced. It is also proving insufficient for eating disorder treatment because medical care only includes hospital visits or office visits, while eating disorder treatment also includes residential, PHP, and IOP, which are not included under parity.



EATING DISORDER TREATMENT

Levels of Care

LEVEL OF CARE	HOW DOES THE PATIENT QUALIFY	WHAT THE PATIENT CAN EXPECT	DOES INSURANCE PROVIDE COVERAGE
INPATIENT (IP)	<ul style="list-style-type: none"> • The patient is medically unstable • The patient needs 24/7 supervision to stay safe 	<ul style="list-style-type: none"> • Average stay ranges from 7 days to 1 month • All meals and snacks are supervised • Locked bathrooms • Most therapy and nutrition sessions are group-based • Patient lives on-site 	<ul style="list-style-type: none"> • Yes, but prior authorization is needed
RESIDENTIAL (RES)	<ul style="list-style-type: none"> • The patient is medically and/or psychologically stable, but they need a structured environment away from home in order to recover 	<ul style="list-style-type: none"> • Average length of stay ranges from a few weeks to a year • All meals and snacks are supervised • Program is a mix of group and individual therapy and nutrition sessions • Patient lives on-site 	<ul style="list-style-type: none"> • Private insurance only, and prior authorization is often needed
PARTIAL HOSPITALIZATION PROGRAM (PHP)	<ul style="list-style-type: none"> • The patient is physically and psychologically stable, but they need daily support to keep from declining 	<ul style="list-style-type: none"> • Average length of stay is 4-8 weeks • Program meets 5-7 days per week during the day • At least two supervised meals per day • Program is a mix of group and individual therapy and nutrition sessions • Patient lives off-site 	<ul style="list-style-type: none"> • Private insurance does, and government funded only does when the program is hospital-based; prior authorization is often needed



EATING DISORDER TREATMENT LEVELS OF CARE

LEVEL OF CARE	HOW DOES THE PATIENT QUALIFY	WHAT THE PATIENT CAN EXPECT	DOES INSURANCE PROVIDE COVERAGE
INTENSIVE OUTPATIENT (IOP)	<ul style="list-style-type: none"> • Patient no longer needs daily support, but they still need a structured environment for recovery 	<ul style="list-style-type: none"> • Average length of stay is 6-12 weeks • Program meets 3 days per week for 3 hours at a time • One supervised meal per session • Therapy and nutrition sessions may be individual and/or group-based • Patient lives off-site 	<ul style="list-style-type: none"> • Private insurance only, and prior authorization might be needed
OUTPATIENT (OP)	<ul style="list-style-type: none"> • Patient needs support to recover, but can function in their day-to-day life with low risk 	<ul style="list-style-type: none"> • Treatment is ongoing, from a few months to a few years • Treatment includes: <ul style="list-style-type: none"> ○ Individual therapy ○ Group therapy ○ Nutrition/dietitian therapy ○ Psychiatry appointments ○ Medical appointments 	<ul style="list-style-type: none"> • Yes, but it is usually limited to in-network providers and there is rarely a mechanism to search for eating disorder specialists
INTENSIVE FAMILY TREATMENT (IFT)	<ul style="list-style-type: none"> • Patient is 24 or younger and lives with family of origin 	<ul style="list-style-type: none"> • Entire family is included in treatment • One-week intensive 	<ul style="list-style-type: none"> • Rarely
FAMILY-BASED THERAPY (FBT)	<ul style="list-style-type: none"> • Patient is an adolescent or an adult who lives with family 	<ul style="list-style-type: none"> • Treatment is therapist-led • Focused on empowering parents to feed their child • Typically runs for 20 sessions 	<ul style="list-style-type: none"> • Rarely

SOURCE: NATIONALEATINGDISORDERS.ORG



SINGLE CASE AGREEMENTS

Q: What is a SCA?

A: A Single Case Agreement (SCA) is a one-time contract between an insurance company and an out-of-network provider for a specific individual so that the patient can see that provider using their in-network benefits. It is essentially an exception to the network so that the patient will only have to pay their routine in-network co-pays for sessions after meeting their in-network deductible (if any). The fee per session that will be paid by the insurance company is negotiated by the insurance company and the provider as part of the SCA.

SCAs can be justified when:

- The provider/treatment program has a clinical specialty, which is not available among any in-network provider.
- The in-network provider does not treat people of your age, gender, or religious preference.
- The geographical location of the patient does not have any in-network providers.
- The out-of-network provider will keep the patient out of the hospital, cutting down the cost of medications.
- A patient who has recently changed their insurance plan (continuity of care).
- All in-network providers are full and have no availability.
- There is proof that the available in-network providers are inappropriate or would cause harm (e.g. the patient is transgender and they need a provider with expertise in working with transgender patients).

Q: How do I set up a SCA?

A: SCAs are typically negotiated directly between your healthcare provider and your insurance company. When you first reach out to your healthcare provider for treatment, you can ask them whether they would be willing to negotiate a SCA with your insurance company. Be prepared to provide details about your medical history and whether you have received eating disorder treatment in the past. The stronger your case is that your chosen provider is the best care for you, the more likely your insurance company will agree to a SCA.

Q: How long does an SCA last?

A: SCAs typically last for the length of your treatment. However, if you complete treatment with your provider and decide to resume treatment at a later date, you would need to negotiate a new SCA with your insurance company.



APPEALING INSURANCE DENIALS

If your health insurance denies coverage for your treatment, you can submit an **appeal**. There are two types of insurance appeals:

- **Internal appeal:** your insurance company does a “full and fair review” of its decision to deny coverage for treatment. You can learn more about internal appeals [here](#).
- **External review:** an independent third party determines whether your insurance company should have denied coverage for treatment. You can learn more about external reviews [here](#).

Appeal Letter Template (source: [University of Rochester Medical Center](#))

Dear [Appeals Analyst]:

I am writing, on behalf of [name of Plan member if other than yourself], to appeal the [name of Health Plan] decision to deny [name of service, procedure, or treatment sought] for [name of Plan member if other than yourself].

It is our understanding that [name of Health Plan] is denying coverage on the basis that “[cite Health Plan’s language in the denial letter].” [Attach denial letter.] We believe that [name of service, procedure, or treatment sought] is medically necessary to treat [name of Plan member if other than yourself]’s medical condition and that [name of service, procedure, or treatment sought] is a covered plan benefit.

[Name of Health Plan] covers medically necessary services that are not expressly excluded, which are described in the Evidence of Coverage and which are authorized by the member’s PCP and in some cases approved by an Authorized Reviewer. [Attach relevant section from Evidence of Coverage.]

The entire treatment team has recommended that [name of service, procedure, or treatment sought] is medically necessary. [Attach supporting medical letter.]

Contrary to your letter, [name of service, procedure, or treatment sought] is a covered service. [Name of service, procedure, or treatment sought] is stated as a covered benefit in your HMO Member Handbook, is implicitly covered in the Evidence of Coverage, and is not expressly excluded as a covered service in the Evidence of Coverage. [Quote from Member Handbook and Evidence of Coverage to establish that the service, procedure, or treatment is a covered benefit and not expressly excluded.] [Cite your state’s mandated benefit laws requiring that the health plan provide this coverage.]



[Describe member's health condition, and why the service, procedure, or treatment would benefit the member and the consequences if the patient does not receive this treatment.]

[If the treatment is out-of-network, establish that there are no comparable services offered within the network.]

[Finally, if you feel they won't cover the service because of the precedent, ask them to consider covering it as an extra-contractual benefit, and to pay for the service, procedure, or treatment out of the Health Plan's catastrophic payment pool.]

[If the member requires immediate treatment for the condition, request an expedited hearing – request that they respond within 72 hours of mailing of the letter. Note that ACA now requires a 72-hour expedited internal review for urgent care. This time frame is required for plan years or policy years beginning on July 1, 2012.]

[Attach a letter from your treating physician describing the person's condition.]

Thank you for your immediate attention to this matter.

*Sincerely,
[Your name]*

cc: [Possible people to whom you should consider sending copies of your letter including Health Plan Medical Director; Medical Group; Medical Director; Your primary care or treating physician; Your state representative if you expect more denials]



ADVOCATING FOR ED TREATMENT WITH MEDICAID

1. Before contacting your managed care Medicaid, start by calling in-state eating disorder treatment centers to ask if they will work with in-state Medicaid through a Single Case Agreement (a one-time contract between insurance company and treatment center to provide a service that is not a covered benefit, or out-of-network, with your insurance). **When calling these facilities, call Admissions/Intake line.**
2. If you cannot find an in-state treatment center, start calling out-of-state treatment centers (if willing to travel out-of-state for placement) to ask if they will work with out-of-state Medicaid for Single Case Agreements (SCA), and let them know what in what state your Medicaid is enrolled as well as through what managed care company. **NY State will usually only work with in-state providers.
3. Once you find a treatment center willing to work with your Medicaid, ask if you can then set up an in-person/phone assessment, and/or what steps are needed to start a SCA (ask if the treatment center will take it from here to set up the SCA or if you will need to take any steps to initiate it).
 - Of note, whether or not you continue the process or the treatment center does, a full clinical assessment by the treatment center and labs/EKG will need to be presented by the treatment center to finalize the SCA and prove medical necessity for the SCA.
 - If you, as a member/patient, are calling your Medicaid about starting SCA, you will only be calling to start the process and to ask your Medicaid if a SCA is possible and how to get it started.

If you are initiating SCA with Medicaid:

1. Call member services number on the back of your insurance card and ask to speak to the authorization team. You will likely be forwarded to an Insurance Care Manager (ICM).
2. Tell ICM you are being referred by your (OP provider/lower level of care/primary care physician, etc.) to a higher level of care (IOP, PHP, Residential) for eating disorder treatment due to current medical and clinical necessity.
3. Tell ICM you are aware that insurance covers in-state/in-network inpatient/outpatient only, but you have exhausted all options (explain options you have tried) and would like to find out what is needed to set up an out-of-network SCA.



4. Tell ICM you have a treatment center you are working with/planning to work with, and the treatment center will call to initiate pre-authorization for SCA for your treatment. Treatment center will provide full clinical/medical necessity for SCA on pre-authorization call.

5. If ICM tells you your primary care physician (PCP) must initiate the SCA pre-authorization, call your physician and explain the situation. Your PCP must be very assertive when attempting to initiate this SCA!

- Before having your PCP call in this authorization, make sure at this point to be set up with a treatment center for an assessment. Also, inform your assessor that Medicaid is requiring your PCP to complete SCA pre-authorization for treatment.
- Sign Release of Information (ROI) with treatment center for your PCP so they can confidentially communicate with each other about your treatment.
- Ask your assessor at treatment center to fax clinical information to PCP. Labs/EKG must be completed by PCP also.
- When PCP has all medical/clinical information, they can initiate pre-authorization by calling provider services number on back on your insurance card and asking to speak with authorization/pre-cert team. Your PCP must say they want to initiate an out-of-network SCA for you for _____ level of care at _____ treatment center.

6. Once all the above pieces are in place and in process, a final, beneficial step is to call member services again and request a case manager. Tell insurance this is urgent, as you are in immediate need of treatment (otherwise, this may take a week or so for them to get back to you). Case management is a free service through Medicaid. You will be assigned a case manager who will be your main contact through Medicaid going forward. Your case manager will also be an inside voice and advocate for you within Medicaid. They will also advocate for your eating disorder treatment and placement within Medicaid.



MEDICAID TREATMENT CENTERS

By State

ARIZONA

Rosewood Center for Eating Disorders

844-921-4504

36075 S Rincon Rd, Wickenburg, AZ

IP; RES; PHP; IOP; Transitional living

CALIFORNIA *MediCal

UCLA- Adolescent program

310-206-3954

IP; Outpatient

COLORADO

Children's Hospital Colorado

720-777-6452

13123 E 16th Ave, Aurora, CO

IP; PHP; IOP; Outpatient

EDCare

303-771-0861

4100 E Mississippi Ave Ste 1300, Denver, CO

PHP; IOP; Outpatient

EDCare Colorado Springs

719-578-51323460 Briargate Blvd, Colorado Springs, CO

IOP

CONNECTICUT

Walden Eating Disorder Center

860-872-525431 Union St, Vernon, CT

IP



ILLINOIS

Alexian Brothers Behavioral Health

855-383-2224

1650 Moon Lake Blvd, Hoffman Estates, IL 60169I

P; PHP; IOP; Outpatient

OSF Saint Francis Eating Disorders

309-655-2738

530 NE Glen Oak Ave, Peoria, IL

PHP; IOP; Outpatient

IOWA

University of Iowa

319-356-1616

200 Hawkins Dr, Iowa City, IA

IP; PHP; Outpatient

MARYLAND

Johns Hopkins

410-955-3863

600 N Wolfe St, Baltimore, MD

IP; PHP; Outpatient

The Center for Eating Disorders- Sheppard Pratt

410-938-3000

6501 N Charles St, Baltimore, MD

IP; PHP; IOP; Outpatient

MASSACHUSETTS

Walden Behavioral Care Main Campus

781-647-6727

9 Hope Ave, Ste 500, Waltham, MA

IP; RES

NEBRASKA

Brandi Stalzer

402-333-0898

bstalzer@omnibehavioralhealth.com

8715 Oak St, Omaha, NE

IP; PHP; Outpatient



NEW MEXICO

Eating Disorder Treatment Center

505-266-6121

holly@eatingdisordersabq.com

5203 Juan Tabo Blvd NE, Ste 2A, Albuquerque, NM

PHP; IOP; Outpatient

NEW YORK

John T Mather Memorial Hospital

631-473-3877

100 Highlands Blvd, Ste 201, Port Jefferson, NY

PHP; IOP

The Healing Connection

585-641-02811387 Fairport Rd Ste 1000D, Fairport, NY

PHP; IOP; Outpatient

Upstate NY Eating Disorders

607-732-5646

1003 Walnut St, Elmira, NY

PHP; IOP

NORTH CAROLINA

UNC Center of Excellence for Eating Disorders

984-974-3834101 Manning Dr CB#7160, Chapel Hill, NC

IP; Outpatient

Transcend ED

704-708-4605134

W Matthews St, Matthews, NC

PHP; IOP; Outpatient

Tapestry Treatment Centers

(844) 628-6625 5010 Hendersonville Road, Fletcher, NC

Residential, PHP, IOP



NORTH DAKOTA

Sanford Eating Disorder

701-461-5300

Route 331 1720 S University Dr, Fargo, ND

PHP; Outpatient

OHIO

Lindner Center of Hope

513-536-46734075

Old Western Row Rd, Mason, OH

IP; PHP; Outpatient

PENNSYLVANIA

UPMC Center for Eating Disorders

412-647-9329

IP; PHP; IOP

Eating Disorders Program at Brandywine

610-383-8701

219 Reeceville Rd, Coatesville, PA

IP

WISCONSIN

Rogers Memorial Hospital- Oconomowoc

262-646-4411

34700 Valley Rd, Oconomowoc, WI

IP; RES; PHP



Non-Medicaid facilities willing to work with IN-STATE & OUT-OF-STATE Medicaid

These facilities are willing to work with Medicaid members/providers and have often worked with out-of-state Medicaid, depending on the state. They will often get more push-back from Medicaid because as they are not facilities contracted with in-state Medicaid, they do not have a Medicaid number.

Center for Discovery Eating Disorder Treatment

877-650-1756

Locations: Northern California, Southern California, Connecticut, Florida, Georgia, Illinois, New Jersey, New York, Oregon, Texas, Virginia, Washington

IOP, PHP, RES

McCallum Place

855-468-0536

Locations: Kansas City, KS and St. Louis, MO

RES

Monte Nido & Affiliates Eating Disorder Centers

888-891-2590

RES Locations: East Bay, Ca; Malibu, CA; Chicago, IL; Boston, MA; Glenwood, MD; Glen Cove, NY; Irvington, NY; Eugene, OR;

PHP Locations: Los Angeles, CA; Newport Beach, CA; Eugene, OR; Portland, OR; Westchester, NY; New York, NY; Philadelphia, PA; Boston, MA

Alsana

866-926-5839

Locations: Birmingham, AL; Monterey, CA; Westlake Village, CA; Santa Barbera, CA; St. Louis, MI

Virtual IOP & PHP, IOP, PHP, Residential

Veritas Collaborative Eating Disorder Treatment

855-875-5812

Child, Adolescent, Adult

GA, NC, VA

Inpatient, Residential, PHP, IOP



Non-Medicaid facilities willing to work with IN-STATE & OUT-OF-STATE Medicaid

These facilities are willing to work with Medicaid members/providers and have often worked with out-of-state Medicaid, depending on the state. They will often get more push-back from Medicaid because as they are not facilities contracted with in-state Medicaid, they do not have a Medicaid number.

Reasons Eating Disorder Center (MediCal)

844-573-2766

4619 Rosemead Blvd, Rosemead, CA 91770

Adult Inpatient, Residential, PHP

Adolescent Inpatient, PHP

The Renfrew Center

*will work with NY Fidelis, Medicaid SCA in NY and PA

800-736-3739

The Renfrew Center of New York

38 W 32nd street, 10th floor New York, NY 10016

IOP, PHP

The Renfrew Center of PA Spring Lane

475 Spring Lane Philadelphia, PA 19138

Residential



LEGAL SUPPORT

Legal Practices that Work on Eating Disorder Litigation

- [Berger & Green \(PA\)](#)
- [Disability Insurance Law Group \(FL\)](#)
- [Kantor & Kantor, LLP \(CA, OR, and WA\)](#)
- [Law Offices of Scott Glovsky \(CA\)](#)

Legal Practices that Deal with Health Insurance and Parity Violations

- [The Kennedy Forum](#)
- [Crowell & Moring LLP \(Kathy Hirata Chin in particular\) \(NY\)](#)
- [DeBofsky Sherman Casciari Reynolds P.C. \(IL\)](#)
- [Dickinson Wright LLP \(AZ, CA, FL, KY, MI, OH, NV, TN, TX, and Washington DC\)](#)
- [Epstein Becker & Green \(CA, CT, FL, IL, MD, MI, NJ, NY, TN, TX, and Washington DC\)](#)
- [Hall Render Killian Heath & Lyman \(AK, CO, IN, MD, MI, NC, TX, WA, WI, and Washington DC\)](#)
- [Napoli Shkolnik PLLC \(Matthew Lavin in particular\) \(Washington DC\)](#)
- [Psych Appeal \(CA\)](#)
- [Zuckerman Spaeder \(FL, MD, NY, and Washington, DC\)](#)

