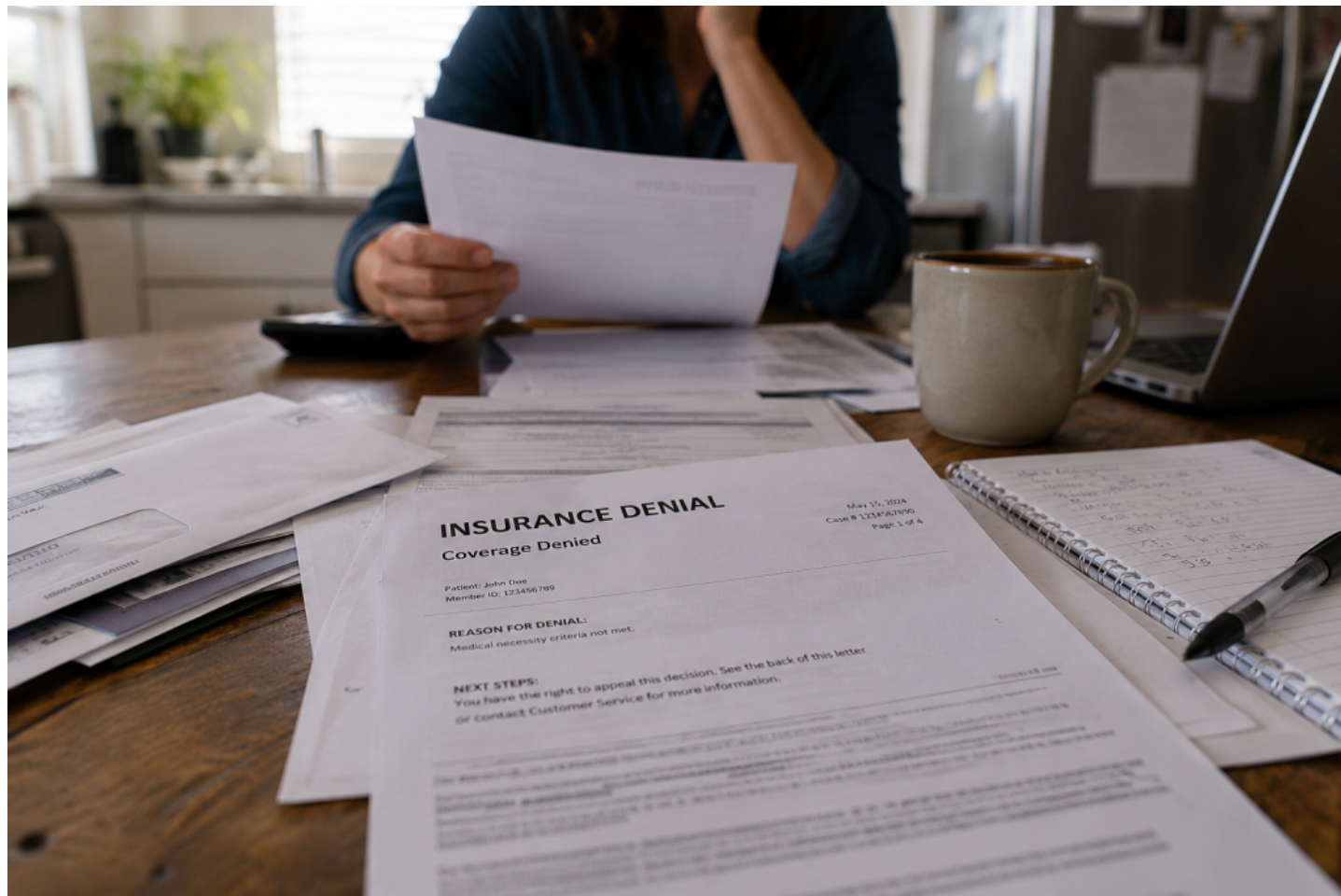


Many Never Appeal Their Insurance Denials. Most Who Do, Win.

Fewer than 1 in 100 denied patients ever challenge the decision. Studies show up to three-quarters of those who do, succeed. A look at the silent gap.



New York City, New York Jun 4, 2026 ([IssueWire.com](https://www.issuewire.com)) - Each year, American health insurers issue roughly 850 million claim denials. Fewer than 1 in 100 are ever appealed. Of the appeals that do get filed, studies show up to three-quarters succeed.

The gap between those two figures is significant. Most patients who could successfully challenge a denial never file an appeal at all.

[Apellica](#), a New York-based insurance appeal service, was built to address that gap.

Patients upload a [health insurance denial letter](#) at apellica.com/start. A senior reviewer examines the denial, identifies the requirements cited by the insurer, outlines applicable deadlines, and explains what supporting documentation may be needed before the appeal window closes.

"By the time they understand what the denial is asking them to fight, the window is often closing," said Mark Henderson of Apellica.

The 180 Day Window

Federal law generally gives most patients 180 days to file an internal appeal after a denial. A majority never do. Some assume the insurer's decision is final. Others cannot determine which clinical standard was applied, what records were missing, or what the insurer would need to see to reverse the decision. The denial letter itself is often written in language that makes the next step difficult to identify.

The consequences appear in patient outcomes. A family pays out of pocket for therapy that should have been covered. A patient skips a follow-up procedure. A prescription goes unfilled. A surgery is postponed while the appeal window passes without action.

For most patients, the appeal window closes before they have understood what the denial was asking them to challenge.

What Apellica Reviews

Apellica has prepared appeals for denials involving autism therapy, post-surgical rehabilitation, mental health treatment, fertility care, GLP-1 weight-loss medications, durable medical equipment, prescription drug coverage refusals, and medical necessity determinations. The company handles both prior authorization denials, where coverage is refused before treatment begins, and post-service claim denials, where coverage is refused after care has been provided.

Every case is reviewed by Apellica's senior review team, which includes attorneys. The company does not use chatbot-generated appeals, automated templates, or mass-produced form letters. Each appeal is prepared for the specific patient and the specific denial, which is challenging.

"Most people do not need a courtroom," Henderson said. "They need someone who has read thousands of these denials, understands what the insurer is asking for, and can prepare the appeal before the deadline closes."

When the Letter Arrives

Patients facing a health insurance denial, prior authorization denial, or prescription drug coverage denial can upload their denial letter at apellica.com/start for review. The initial review is free and requires no payment information. Patients receive the review before deciding whether to proceed. If a patient chooses to proceed, Apellica charges 10 percent of any recovered amount and nothing if no recovery is made.

For most Americans, the denial letter remains the only part of the insurance system they ever engage with. Apellica was built to change that.

[About Apellica](#)

Apellica is an insurance appeal preparation service headquartered at One World Trade Center in New York. It works with patients in all 50 states. Apellica is not a law firm and does not provide legal advice.

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