Sample Letter of Appeal

[Physician practice letterhead]

ATTN:
[Contact Name/Medical Director]
[Insurance Company Name]
[Insurance Company Street Address]
[Insurance Company City, State, Zip]

RE:
[Insured Patient Name]
Date of birth: **[Patient DOB]**
Policy number: **[Policy #]**
Group number: **[Group #]**

Reference Number: **[Reference Number / Appeal Number]**
Therapy: **[Insert Product Name]**
Submission Date: **[Submission Date]**
Denial Date: **[Denial Date]**

Dear Medical Reviewer / Appeals Reviewer,

I am writing on behalf of my patient, **[patient name]**, to request an appeal by a Medical Advisor of the above-mentioned denial for coverage of **[insert product name]**. Based on the letter of denial, it is my understanding **[insert product name]** has been denied for the following reason(s):

- **[Insert denial reason from the denial letter]**

Based on my medical expertise, I ask that you reconsider this decision. **[insert product name]** is **[insert brief product and indication description]**. I believe that **[Patient Name]** would benefit from **[insert product name]** for the following reason(s):

- **[Insert rationale]**

Enclosed, please find additional documentation to support this rationale:

- **[Attach any relevant medical literature]**
- **[Attach any relevant clinical documentation]**

In summary and based on my clinical judgment, I request that you consider reversing the previous denial. Please call my office at **[telephone number]** if you require any additional information or documentation. I look forward to your timely response.

Sincerely,

[Insert Physician Name and Participating Provider Number]