

[PHYSICIAN PRACTICE LETTERHEAD]

Date:

To: [Name of Insurance Company]

[Address]

[City], [State] [ZIP Code]

Re: [Patient name]

Diagnosis: [Patient's diagnosis & ICD-10-CM Code]

Policy Number:

Group Number:

Subscriber Name:

To Whom It May Concern:

I am writing on behalf of my patient [insert name], policy number [insert number], to request an appeal. [Insert drug name] was administered to [insert patient name] on [insert date of service]. [Insert drug name] has been approved by the FDA for [insert disease]. You have indicated that [insert drug name] is not covered by [insert insurance company] because [insert reason for denial from Explanation of Benefits].

[Provide a brief description of the patient's medical history, treatments, and response to drug treatment.]

[Insert patient name] has had a diagnosis of [insert diagnosis] since [insert date] at the age of [insert age]. I have administered [insert drug name] to [insert patient name] as a medically necessary part of [his/her] treatment. I would appreciate a reconsideration of the claim from [insert date of service] for [insert patient name]. To further support the medical necessity of this patient's treatment with [insert drug name], I am including the following information:

[Bullet out a list of the documentation provided with the request such as product information, clinical literature, and information from the patient's medical record]

Based on this patient's diagnosis, disease severity, and medical history, I believe that [insert drug name] is appropriate and medically necessary for this patient, and request an appeal of the denied claim.

If you have any further questions, please contact me at [insert phone number] to discuss. Thank you in advance for your immediate attention to this request for treatment.

Sincerely,

[Insert physician name, practice name, and address]

[Attach supporting documentation such as MRI results, chart notes, etc]