[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Second-Level Formal Appeal for [Type of Imaging, e.g., MRI/CT Scan]
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID Number: [ID Number]
Claim/Reference Number: [Reference Number]
Date of Denial: [Date]

To the Appeals Review Committee,

I am writing to formally request a second-level appeal regarding the denial of coverage for a [Specific Imaging Procedure] requested by my physician, [Physician Name]. This procedure was denied on [Date] on the grounds that [Reason for Denial from Letter].

I have already completed the first-level appeal process, which resulted in a continued denial. I am now requesting an independent review by a medical professional in the same specialty as my treating physician to evaluate the clinical necessity of this diagnostic imaging.

My physician has determined this imaging is medically necessary for the following reasons:

- [Clinical reason 1: e.g., Failure of conservative treatments like physical therapy]
- [Clinical reason 2: e.g., Progression of symptoms or neurological deficit]
- [Clinical reason 3: e.g., Need for surgical planning]

Attached to this letter, please find additional supporting documentation, including updated clinical notes, results of previous tests, and a letter of medical necessity from my doctor. These records demonstrate that the requested imaging meets the standard of care for my condition.

Failure to approve this diagnostic tool delays essential treatment and risks further injury or complications. Please review this second-level appeal and provide a written determination within the timeframe required by my policy.

Thank you for your immediate attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from Dr. [Name]
Relevant Medical Records/Test Results
First-Level Appeal Denial Letter