[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 Appeal for Denial of Prior Authorization

Patient Name: [Patient Name]
Member ID Number: [ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number]
Date of Initial Denial: [Date]
Date of First-Level Appeal Denial: [Date]

Dear Appeals Committee,

I am writing to formally request a second-level appeal regarding the denial of coverage for [Name of Procedure, Medication, or Service]. This request is based on the medical necessity of the treatment as prescribed by my physician, [Physician Name].

I am appealing this decision because the previous denial does not adequately account for my specific clinical history and the failure of alternative treatments. [Briefly describe the medical condition and why the requested treatment is essential].

Attached to this appeal, please find additional clinical documentation that was not previously reviewed, including:

- A letter of medical necessity from [Physician Name] providing detailed clinical justification.
- Peer-reviewed clinical studies supporting the efficacy of [Treatment Name] for my condition.
- Relevant laboratory results and imaging reports from [Dates].
- A history of failed treatments [List specific medications or therapies].

The requested treatment is the standard of care for my diagnosis and is vital to preventing [mention potential complications or worsening of condition]. I request that a physician specialist in [Medical Specialty] who was not involved in the initial or first-level denial reviews this case.

Please provide a written response regarding your decision within [Number] days, as required by the policy guidelines. Thank you for your time and reconsideration of this urgent matter.

Sincerely,

[Your Signature]

[Your Printed Name]