

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Policy/Member ID Number]

[Date]

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

RE: Second-Level Formal Appeal for [Medication Name]

Claim/Reference Number: [Reference Number from Denial Letter]

Patient Name: [Patient Name]

Date of Birth: [DOB]

To the Appeals Review Committee,

I am writing to formally request a second-level appeal regarding the denial of coverage for [Medication Name], prescribed by my physician, [Physician Name]. This medication was denied on [Date of First Denial] and subsequently upheld on [Date of First Appeal Decision].

I am requesting that you reconsider this decision based on the following medical necessity factors:

- **Treatment History:** I have previously tried and failed the following formulary alternatives: [List medications tried] due to [reason for failure, e.g., lack of efficacy or adverse side effects].
- **Clinical Justification:** My provider has determined that [Medication Name] is the only appropriate treatment for my condition, [Diagnosis Name], because [explain why this specific drug is necessary].
- **Risk of Non-Treatment:** Without this specific medication, I am at risk for [list potential health complications].

Attached to this letter, please find additional supporting documentation, including updated clinical notes from my specialist, recent lab results, and a letter of medical necessity from my physician.

I request a timely review of this second-level appeal as my health depends on access to this therapy. Please provide a written response regarding your decision within [number of days required by law/policy] days.

Thank you for your immediate attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List attached documents, e.g., Physician Letter, Medical Records]