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

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

RE: Second-Level Appeal for [Patient Name]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]
Date of Denial: [Date of First Appeal Denial]

Dear Appeals Committee,

This letter serves as a formal second-level appeal regarding the denial of coverage for [Name of Outpatient Procedure]. The initial request and the first-level appeal were denied on the grounds of [State Reason Given in Denial Letter, e.g., lack of medical necessity]. I strongly disagree with this decision and request an independent review of my case.

My physician, Dr. [Physician Name], has determined that this procedure is medically necessary because [Briefly explain why the procedure is needed, mentioning specific symptoms or failed previous treatments].

Included with this appeal are the following documents for your reconsideration:

- A letter of medical necessity from my treating physician.
- Relevant clinical notes and diagnostic test results.
- Peer-reviewed medical literature supporting the efficacy of this procedure for my condition.
- A copy of the previous denial letters.

The denial of this outpatient procedure significantly impacts my health and quality of life. I urge you to review the attached medical evidence and reverse the prior decision.

I look forward to your written response within the timeframe mandated by my policy. Please contact me at [Your Phone Number] if you require further information.

Sincerely,

[Your Signature]
[Your Printed Name]