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

[Date]

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

RE: Second-Level Appeal for Specialist Referral Denial

Member Name: [Member Name]
Member ID Number: [ID Number]
Claim/Reference Number: [Reference Number]
Provider Name: [Specialist Physician Name]

To the Appeals Committee,

I am writing to formally request a second-level appeal regarding the denial of a prior authorization for a referral to [Specialist Name/Specialty]. The initial request was denied on [Date of First Denial], and the first-level appeal was upheld on [Date of Appeal Denial].

I am appealing this decision because the requested specialist care is medically necessary for the following reasons:

- [Reason 1: Describe why your current primary doctor cannot treat the condition].
- [Reason 2: Explain how this specialist has the specific expertise required for your diagnosis].
- [Reason 3: Mention any failed treatments or tests that necessitate a higher level of care].

Enclosed, please find additional supporting documentation, including [list documents, e.g., updated medical records, a letter of medical necessity from your primary physician, or clinical guidelines]. These documents demonstrate that the requested referral is the standard of care for my condition.

I request that a physician of the same specialty as the requested provider reviews this second-level appeal. I look forward to your timely response within [Number of days required by law/policy] days.

Sincerely,

[Your Signature]

[Your Printed Name]