

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

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

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

**Patient Name:** [Patient Name]

**Member ID:** [ID Number]

**Group Number:** [Group Number]

**Case/Reference Number:** [Reference Number from Denials]

To the Appeals Committee,

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

I am requesting that this case be reviewed by an independent medical professional who specializes in [Specific Medical Specialty, e.g., Rheumatology/Gastroenterology/Dermatology].

The denial stated that [Insert Reason for Denial from letter, e.g., "The medication is not considered medically necessary" or "Step therapy was not completed"]. However, I believe this treatment is vital for the following reasons:

- **Clinical Justification:** [Detail your diagnosis and the severity of your symptoms].
- **Previous Treatment Failure:** I have already tried and failed the following therapies: [List drug names, dates of use, and why they failed-e.g., side effects or lack of efficacy].
- **Medical Necessity:** [Medication Name] is the standard of care for my condition because [Insert reason, e.g., specific biomarkers or contraindications to other drugs].
- **Risk of Non-Treatment:** Without this biologic therapy, I am at significant risk for [List risks, e.g., permanent joint damage, hospitalization, or organ failure].

Attached you will find a letter of medical necessity from my physician, my relevant clinical records, and peer-reviewed studies supporting the use of [Medication Name] for my specific case.

I look forward to your prompt response within the timeframe required by law. Please contact me at [Phone Number] or my physician's office at [Doctor's Phone Number] if you require further information.

Sincerely,

[Your Signature]  
[Your Printed Name]

**Enclosures:**

- Physician Letter of Medical Necessity
- Clinical Notes and Lab Results
- Relevant Medical Journal Articles