[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 Formal Appeal for Denial of Authorization
Patient Name: [Patient Name]
Member ID Number: [ID Number]
Claim/Reference Number: [Reference Number]
Date of First-Level Denial: [Date]

Dear Appeals Committee Member,

I am writing to formally request a second-level appeal regarding the denial of coverage for [Requested Treatment/Medication/Service]. This request follows the initial denial and the subsequent first-level appeal denial received on [Date].

I strongly disagree with the determination that this treatment is [not medically necessary / experimental / other reason cited in denial]. My treating psychiatrist, [Doctor Name], has determined that this treatment is vital for my clinical stabilization and long-term recovery for the following reasons:

- **Clinical Justification:** [Briefly describe why previous treatments failed and why this specific treatment is necessary].
- **Risk of Non-Treatment:** [Briefly describe potential risks such as hospitalization or severe regression].
- **Adherence to Guidelines:** [Mention if the treatment follows APA or other standard psychiatric guidelines].

Enclosed, please find additional documentation to support this appeal, including [List attachments: e.g., updated clinical notes, a formal letter of medical necessity from my physician, and relevant peer-reviewed studies].

I request that a board-certified psychiatrist who is not an employee of [Insurance Company Name] and was not involved in the previous denial decisions review this case. This treatment is essential for my mental health and functional independence.

Please provide a written response regarding your decision within the timeframe mandated by state law and my policy guidelines. Thank you for your immediate attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
1. Letter of Medical Necessity from [Doctor Name]
2. Relevant Medical Records
3. Copies of previous denial letters