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

[Date]

[Name of External Review Organization or State Department of Insurance]
[Address]
[City, State, Zip Code]

RE: Request for External Independent Review
Patient Name: [Patient Name]
Insurance Member ID: [Member ID Number]
Group Number: [Group Number]
Reference/Case Number: [Reference Number from Denial Letter]
Service Requested: MRI of [Body Part, e.g., Lumbar Spine]

To Whom It May Concern,

I am writing to formally request an External Independent Review of a denied prior authorization for an MRI requested by my physician, [Doctor's Name]. The insurance company, [Insurance Company Name], has issued a final adverse determination upholding the denial of this procedure on the grounds that it is [mention reason for denial, e.g., not medically necessary].

I have exhausted the internal appeals process provided by the insurance company. I disagree with their decision for the following reasons:

- [Reason 1: Describe symptoms, duration of pain, or failure of conservative treatments like physical therapy].
- [Reason 2: Reference specific clinical guidelines or the doctor's recommendation].
- [Reason 3: Explain why this specific diagnostic tool is necessary for further treatment planning].

Attached to this request, please find:

- The final denial letter from [Insurance Company Name].
- A letter of medical necessity from my treating physician.
- Relevant medical records and imaging reports.
- Signed authorization form for the release of medical records.

I request that an independent medical professional review this case to ensure that I receive the necessary care as recommended by my doctor. Thank you for your time and assistance with this matter.

Sincerely,

[Your Signature]

[Your Printed Name]