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

[Date]

[Name of Health Insurance Company/Regulatory Body]
[Attn: Appeals/External Review Department]
[Address]
[City, State, Zip Code]

RE: REQUEST FOR EXPEDITED EXTERNAL INDEPENDENT REVIEW

Patient Name: [Patient Name]
Policy Number: [Policy Number]
Claim/Reference Number: [Reference Number]
Denied Treatment: [Name of Oncology Treatment/Drug/Procedure]

To Whom It May Concern,

I am writing to formally request an **Expedited External Independent Review** regarding the denial of coverage for the oncology treatment mentioned above. I have exhausted the internal appeals process with [Insurance Company Name], and the final adverse determination was received on [Date].

This request is for an **expedited** review because my treating oncologist, [Doctor's Name], has determined that the standard timeframe for a review would seriously jeopardize my life, health, or ability to regain maximum function. As this involves a diagnosis of [Specific Type of Cancer], time is of the essence to prevent the progression of the disease.

Reason for Review:
The denial was based on [Reason given by insurance, e.g., "Medical Necessity" or "Experimental/Investigational"]. However, my physician has determined this treatment is the medically necessary standard of care for my condition because: [Briefly list reason, e.g., failure of previous therapies or specific genetic markers].

Enclosed please find:

- A signed Physician's Certification of Medical Necessity for Expedited Review.
- Copies of relevant medical records and pathology reports.
- Peer-reviewed clinical studies supporting the use of this treatment for my diagnosis.
- The final denial letter from [Insurance Company Name].

Please notify me immediately of your decision regarding this request. I can be reached at [Phone Number] or [Email Address].

Sincerely,

[Your Signature]
[Your Printed Name]