Date: [Date]

TO: [Independent Review Organization Name]
ATTN: External Review Department
ADDRESS: [IRO Address]
RE: Appeal for [Patient Name]
PATIENT DOB: [Patient Date of Birth]
INSURANCE ID: [Member ID Number]
CLAIM/REFERENCE #: [Denial Reference Number]

To Whom It May Concern,

I am writing to formally request an external independent review of the denial of coverage for [Name of Procedure/Drug/Service] for my patient, [Patient Name]. I have been treating this patient for [Duration of Time] for the diagnosis of [Diagnosis Name and ICD-10 Code].

Clinical Background:
[Patient Name] presents with [Summary of clinical symptoms and history]. To date, the patient has attempted and failed the following treatments: [List previous medications, therapies, or surgeries]. These treatments were unsuccessful because [Explain why they failed or were contraindicated].

Medical Necessity:
I have prescribed [Requested Service] because it is medically necessary according to evidence-based clinical standards. This treatment is required to [State goal: e.g., prevent permanent disability, manage chronic pain, or sustain life]. Without this specific intervention, the patient is at significant risk for [List potential complications or clinical decline].

Rationale for Overturning Denial:
The previous denial stated that the requested service was [Reason given by insurance, e.g., experimental or not medically necessary]. I disagree with this assessment because [Provide clinical rebuttal and cite specific medical literature or guidelines]. Specifically, [Link the patient's unique clinical data to the requested service].

Conclusion:
Based on the patient's clinical history and the lack of viable alternatives, I strongly urge the review board to overturn the previous denial and authorize [Requested Service]. Attached you will find [List attachments: e.g., clinical notes, test results, and peer-reviewed studies].

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Specialty]

[Practice Name]
[NPI Number]