[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

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

RE: Request for External Independent Review

Patient Name: [Patient Name]
Member ID Number: [Member ID]
Health Plan Name: [Insurance Company Name]
Claim/Reference Number: [Reference Number]
Requested Procedure: [Name of Surgical Procedure]

To Whom It May Concern,

I am writing to formally request an external independent review regarding the denial of coverage for the surgical procedure mentioned above. My insurance company has issued a final adverse determination upholding the denial after the internal appeals process.

The insurance company denied this procedure on the basis that it is [Reason for Denial, e.g., Not Medically Necessary / Experimental]. I disagree with this assessment because this surgery is a critical component of my treatment plan and is supported by my healthcare providers.

Enclosed please find the following documentation to support this request:

- A letter of medical necessity from my surgeon, [Surgeon Name].
- Relevant medical records and diagnostic test results.
- Peer-reviewed clinical studies supporting the effectiveness of this procedure.
- Copies of the initial denial and the final internal appeal decision from the insurance company.

I request that an independent medical professional review these materials and overturn the insurance company's decision. This procedure is necessary to treat [Diagnosis/Condition] and to prevent further health complications.

Thank you for your time and attention to this matter. I look forward to your decision.

Sincerely,

[Your Signature]

[Your Printed Name]