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

[Date]

[State Insurance Commissioner Name, if known]
[Office of the Insurance Commissioner]
[Consumer Protection/Appeals Division]
[Address]
[City, State, Zip Code]

RE: Request for External Independent Review

Insured Name: [Name of Patient/Insured]
Insurance Company: [Name of Insurance Carrier]
Policy Number: [Policy/Member ID Number]
Claim/Reference Number: [Claim Number or Internal Appeal Number]

Dear Commissioner,

I am writing to formally request an External Independent Review of a final adverse benefit determination made by [Insurance Company Name] regarding [Description of Medical Service/Treatment/Medication].

I have exhausted the internal appeals process provided by the insurance company. On [Date of Final Denial Letter], I received a final notice of denial stating that the requested service was denied based on [Reason for Denial, e.g., Medical Necessity, Experimental/Investigational].

I disagree with this determination because [Briefly state why the service is necessary, e.g., "The treatment is the standard of care for my condition" or "My physician has documented that other treatments have failed"].

Enclosed are the following documents for your review:

- A copy of the final denial letter from the insurance company.
- A signed medical records release authorization.
- Letters of medical necessity from my treating physician, [Doctor's Name].
- [List any other supporting medical documentation].

Please notify me if any additional information or forms are required to begin the independent review process. I look forward to your timely response regarding this matter.

Sincerely,

[Your Signature]

[Your Printed Name]