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

[Date]

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

RE: Notice of Exhaustion of Internal Appeals and Request for External Independent Review

Patient Name: [Patient Full Name]
Insured Name: [Name of Policy Holder]
Insurance Company: [Name of Health Insurance Plan]
Policy/Member ID Number: [ID Number]
Claim/Reference Number: [Claim Number]

To Whom It May Concern,

I am writing to formally request an External Independent Review of a denied medical claim/service by [Name of Insurance Company].

As of [Date of Final Internal Denial Letter], I have officially exhausted all internal appeal processes provided by my health insurance plan. My request for [Name of Procedure, Service, or Medication] was originally denied on [Initial Denial Date]. I subsequently filed [Number] levels of internal appeals, all of which resulted in the insurance provider upholding their original decision to deny coverage.

The insurance company's final reason for denial is [State Reason, e.g., Medical Necessity, Experimental/Investigational]. I disagree with this determination because [Briefly state why the service is necessary or why the denial is incorrect].

Enclosed are the following documents to support my request:

- Copies of all denial letters from the insurance company.
- The final internal appeal decision letter (Letter of Exhaustion).
- Supporting medical records and a letter of support from my treating physician.
- [Any other relevant documentation].

I authorize the release of my medical records to the Independent Review Organization for the purpose of this review. I look forward to a timely resolution regarding this matter.

Sincerely,

[Your Signature]

[Your Printed Name]