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

[Date]

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

RE: Request for External Independent Review

Patient Name: [Patient Name]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Case Number from Denial Letter]
Medication Requested: [Name of Medication]

To Whom It May Concern,

I am writing to formally request an External Independent Review of the final adverse determination made by [Insurance Company Name] regarding the denial of coverage for [Name of Medication]. I have exhausted the internal appeals process provided by the insurer, and the denial was upheld on [Date of Final Internal Denial].

My physician, Dr. [Physician Name], has prescribed this medication to treat [Medical Condition]. The insurer has denied coverage based on [Reason for Denial, e.g., Medical Necessity/Not on Formulary/Experimental].

I disagree with this decision for the following reasons:

- [Reason 1: e.g., I have tried alternative medications A and B with no success.]
- [Reason 2: e.g., This medication is the standard of care for my specific diagnosis.]
- [Reason 3: e.g., Discontinuing or failing to start this medication poses a serious risk to my health.]

Attached please find the following supporting documentation:

- The final denial letter from [Insurance Company Name].
- A letter of medical necessity from my treating physician.
- Relevant medical records and clinical trial data.

I request that an independent medical professional review this case to overturn the insurer's decision. Please notify me of the receipt of this request and the expected timeline for a decision.

Thank you for your time and assistance in this matter.

Sincerely,

[Your Signature]

[Your Printed Name]