Date: [Insert Date]

To: [Independent Review Organization Name]
[Address]
[City, State, Zip Code]

RE: External Independent Review Request

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Insurance ID Number]
Claim/Reference Number: [Original Denial Reference Number]

To Whom It May Concern,

This letter serves as a formal request from [Medical Clinic Name] for an external independent review of the denial issued by [Insurance Company Name] regarding the following requested service/procedure: [Name of Procedure or Medication].

The health plan has denied coverage based on the assertion that the treatment is [select one: not medically necessary / experimental / investigational]. We strongly disagree with this determination.

Clinical Justification:

[Insert a brief summary of the patient's diagnosis and why this specific treatment is necessary for their care. Mention if other treatments have failed.]

Supporting Documentation Attached:

- Copy of the Final Internal Appeal Denial Letter
- Patient Medical Records and History
- Provider's Statement of Medical Necessity
- Peer-Reviewed Literature/Clinical Guidelines supporting the treatment

We request that the Independent Review Organization overturn the previous denial to ensure the patient receives the standard of care required for their condition. Please contact our office at [Phone Number] or [Email Address] should you require further information.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Medical Clinic Name]
[Clinic Address]