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

[Date]

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

RE: Request for External Independent Review

Patient Name: [Patient Name]
Insurance Member ID: [ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]
Health Plan: [Name of Insurance Company]

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 Physical Therapy services.

The requested services were denied on the grounds that [State the reason for denial, e.g., "the treatment was not medically necessary"]. I have exhausted all internal appeal processes provided by the insurance company, and the denial was upheld on [Date of final internal appeal decision].

I am requesting this review because [Briefly state why the service is necessary, e.g., "The physical therapy is required to regain mobility following surgery/injury and is the standard of care as documented by my physician"].

Enclosed are the following documents to support my request:

- Copy of the final internal appeal denial letter.
- A letter of medical necessity from my treating provider, [Doctor's Name].
- Relevant physical therapy progress notes and clinical records.
- [List any other supporting documents].

I authorize the release of my medical records to the independent review organization for the purpose of this review. Please notify me of the decision within the timeframe required by law.

Thank you for your time and assistance in this matter.

Sincerely,

[Your Signature]
[Your Printed Name]