[Physician Name/Clinic Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

**RE: Peer-to-Peer Review and Authorization Request**
**Patient Name:** [Patient Name]
**Date of Birth:** [DOB]
**Member ID:** [Member ID Number]
**Reference/Reference Number:** [Denial Reference Number]
**Requested Service:** [Name of Procedure/Medication/Treatment]

To the Medical Director,

I am writing to formally appeal the denial of coverage for the above-referenced service and to request a Peer-to-Peer clinical review. I believe this treatment is medically necessary for the patient's condition based on the clinical summary provided below.

**Clinical Summary:**

- **Diagnosis:** [Primary Diagnosis and ICD-10 Code]
- **Patient History:** [Brief history of the condition and duration of symptoms]
- **Prior Treatments:** [List medications, therapies, or procedures failed, including dates]
- **Current Clinical Status:** [Current symptoms and physical exam findings]

**Clinical Rationale for Authorization:**

[Explain why the requested service is the standard of care. Reference specific clinical guidelines or peer-reviewed literature that support the use of this treatment for this specific patient.]

**Peer-to-Peer Request:**

I would like to discuss this case with a physician reviewer of the same specialty. Please contact my office at [Phone Number] to schedule a Peer-to-Peer discussion. My preferred availability is [Time/Days].

Thank you for your immediate attention to this matter. I look forward to resolving this authorization request to ensure the patient receives necessary care.

Sincerely,

[Physician Signature]
[Printed Physician Name]
[Medical Specialty]
[NPI Number]