

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

[Date]

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

**RE: First Level Appeal for Denial of [Procedure/Medication Name]**

**Patient Name:** [Patient Name]

**Member ID Number:** [Member ID Number]

**Group Number:** [Group Number]

**Claim Number / Reference Number:** [Reference Number]

**Date of Service:** [Date of Service]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Procedure/Medication/Service], which was requested by my physician, [Doctor's Name]. The reason for the denial stated in your letter dated [Date of Denial Letter] was "lack of medical necessity."

I believe this service is medically necessary for the following reasons:

- **Diagnosis:** I have been diagnosed with [Condition], which causes [List Symptoms].
- **Previous Treatments:** I have already tried [List previous treatments, medications, or therapies] without success.
- **Clinical Justification:** [Doctor's Name] has determined that [Procedure/Medication] is the standard of care for my specific condition because [Explain why this specific treatment is needed].

Failure to receive this treatment may result in [List potential health risks or complications].

Attached to this letter, please find supporting documentation, including:

- A letter of medical necessity from [Doctor's Name].
- Relevant medical records and test results.
- Peer-reviewed clinical guidelines or studies supporting this treatment.

I request that you reconsider your decision and approve coverage for this medically necessary service. I look forward to receiving your written response within the timeframe required by my policy.

Sincerely,

[Your Signature]

[Your Printed Name]