

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

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

**RE: EXPEDITED URGENT APPEAL**

**Patient Name:** [Patient Name]  
**Member ID:** [Member ID Number]  
**Claim/Reference Number:** [Reference Number]  
**Provider Name:** [Doctor's Name]

To Whom It May Concern,

I am writing to formally request an **Expedited Urgent Appeal** regarding the denial of coverage for [Name of Procedure, Treatment, or Medication]. This request is based on the denial letter dated [Date of Denial Letter] stating a lack of medical necessity.

I am requesting an expedited review because the standard 30-day appeal timeline would seriously jeopardize the patient's life, health, or ability to regain maximum function. [Briefly describe the urgent medical risk or worsening symptoms].

The requested treatment is medically necessary because:

- [Reason 1: Previous treatments that failed]
- [Reason 2: Expected clinical outcome]
- [Reason 3: Clinical guidelines or peer-reviewed evidence]

Attached is a letter of medical necessity from my treating physician, [Doctor's Name], as well as relevant clinical records supporting this urgent need.

Please process this appeal within the 72-hour window mandated for expedited requests. I look forward to your immediate response.

Sincerely,

[Signature]  
[Printed Name]