

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

[Date]

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

**RE: Denial Appeal for [Patient Name]**  
**Member ID:** [Member ID Number]  
**Claim/Reference Number:** [Reference Number]  
**Service Requested:** [Type of Imaging, e.g., MRI/CT Scan]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for the diagnostic imaging procedure mentioned above, which was denied on [Date of Denial] based on a perceived lack of medical necessity.

My treating physician, [Doctor's Name], has recommended this [MRI/CT/PET Scan] to evaluate the following symptoms: [List symptoms or condition]. This imaging is necessary because:

- Previous conservative treatments (e.g., physical therapy, medications) have failed to resolve the issue.
- Other diagnostic tests (e.g., X-rays, blood work) have provided inconclusive results.
- The imaging is required to determine the specific course of treatment or surgical intervention.

Attached you will find a letter of medical necessity from my physician, as well as relevant medical records and clinical guidelines that support the use of this diagnostic tool for my specific diagnosis.

I request that you reconsider your decision and approve the authorization for this procedure. I look forward to your written response within the timeframe required by my policy.

Sincerely,

[Your Signature]  
[Your Printed Name]