

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

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

RE: Formal Appeal of Denial for [Name of Surgical Procedure]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for [Name of Procedure], which was requested by my physician, [Physician's Name]. The reason provided for the denial was a lack of medical necessity.

I believe this procedure is medically necessary to treat my diagnosis of [Name of Condition]. This condition has caused the following symptoms and limitations in my daily life: [List symptoms, e.g., chronic pain, loss of mobility, etc.].

Before recommending this surgery, my physician and I attempted the following conservative treatments without success:

- [Treatment 1, e.g., Physical Therapy] from [Date] to [Date]
- [Treatment 2, e.g., Specific Medications]
- [Treatment 3, e.g., Injections or Lifestyle Changes]

Attached to this letter, please find supporting documentation including:

- A letter of medical necessity from my surgeon, [Physician's Name].
- Relevant medical records, imaging reports (MRI, X-ray, etc.), and test results.
- Peer-reviewed clinical guidelines supporting this procedure for my specific condition.

Failure to undergo this surgery will likely result in [mention potential risks of not having surgery, such as permanent nerve damage or worsening disability]. I request that you reconsider your decision and approve coverage for this essential treatment.

I look forward to your written response within the timeframe required by my policy. Please contact me at [Phone Number] if you require any further information.

Sincerely,

[Signature]

[Your Printed Name]