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

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

RE: Appeal of Coverage Denial
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

To Whom It May Concern,

I am writing to formally appeal your decision to deny coverage for the laboratory test [Name of Test], performed on [Date]. The denial letter states that the test was not considered medically necessary.

This test was ordered by my physician, Dr. [Doctor's Name], to [diagnose/monitor/treat] my condition of [Name of Medical Condition]. Based on my clinical history and symptoms, which include [List symptoms or previous failed treatments], this specific test was essential for determining the appropriate course of my medical care.

Attached you will find a letter of medical necessity from my doctor, relevant medical records, and [mention any peer-reviewed literature or clinical guidelines if applicable] that support the use of this test for my specific diagnosis.

I request that you reconsider your denial and provide coverage for this laboratory service. Please review the additional information provided and notify me of your decision within the timeframe required by my policy.

Thank you for your time and professional consideration of this appeal.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
- Copy of Denial Letter

- Physician Letter of Medical Necessity
- Relevant Medical Records