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

[Date]

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

RE: Appeal of Coverage Denial for Specialist Referral
Member Name: [Your Full Name]
Member ID Number: [Your ID Number]
Reference/Claim Number: [Reference Number from Denial Letter]
Provider Name: [Referring Doctor's Name]

To the Appeals Department,

I am writing to formally appeal the denial of my referral to [Specialist Name/Specialty] dated [Date of Denial Letter]. The reason for denial was stated as a "lack of medical necessity." I believe this referral is medically necessary for the proper diagnosis and treatment of my condition.

I have been diagnosed with [Name of Condition/Symptoms]. My primary care physician, [Referring Doctor's Name], has determined that my condition requires the advanced expertise of a specialist because [Briefly describe why general treatment is insufficient, e.g., symptoms are worsening, previous treatments failed, or specific diagnostic equipment is needed].

Enclosed, please find supporting documentation for this appeal, including:

- A letter of medical necessity from my primary care physician.
- Relevant medical records and diagnostic test results.
- [List any other relevant documents].

I request that you reconsider this denial and authorize the referral so that I may receive the essential care required for my health. I look forward to your response within the timeframe required by my policy.

Sincerely,

[Your Signature]

[Your Printed Name]