

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

[Date]

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

RE: Notice of Denial of Medical Coverage

Patient Name: [Patient Name]

Member ID Number: [ID Number]

Claim/Reference Number: [Reference Number]

Date of Denial: [Date on Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Procedure/Medication/Service] prescribed by my physician, [Physician Name]. The request was denied on the grounds that the service was not deemed "medically necessary."

I believe this service is medically necessary for the following reasons:

- [Reason 1: Briefly describe your diagnosis and symptoms].
- [Reason 2: List previous treatments/medications that failed or were ineffective].
- [Reason 3: Explain why this specific treatment is essential for your health according to your doctor].

Attached to this letter, please find supporting documentation, including a letter of medical necessity from my physician, relevant medical records, and [List any other attachments, e.g., clinical guidelines or peer-reviewed studies].

I request that you reconsider this denial and approve the authorization for the requested service immediately. Please provide a written response within [Number] days as required by my plan's guidelines.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]