[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 Retroactive Claim Denial
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

Dear Appeals Committee,

I am writing to formally appeal the retroactive denial of the claim for services provided on [Date of Service]. Your notice dated [Date of Denial Notice] states that the claim was denied because the services were "not medically necessary."

I strongly disagree with this determination. The services provided were essential for the diagnosis and treatment of [Condition/Diagnosis]. These services were recommended by my physician, [Physician Name], based on clinical symptoms and medical history. At the time the services were rendered, they were understood to be covered under my policy.

The medical necessity of this treatment is supported by the following:

- [Reason 1: e.g., Failure of more conservative treatments]
- [Reason 2: e.g., Adherence to established clinical guidelines]
- [Reason 3: e.g., Risks associated with not receiving the treatment]

Enclosed, please find supporting documentation, including a letter of medical necessity from my physician, relevant medical records, and [any other supporting documents].

I request that you review this claim again and reverse the retroactive denial. Please provide a written response regarding your decision within [number of days, e.g., 30] days.

Thank you for your time and consideration of this appeal.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from Dr. [Name]
Medical Records for Date of Service [Date]
Copy of Original Denial Letter