[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 Appeal for Denied Outpatient Treatment

Patient Name: [Patient Full Name]
Member ID Number: [ID Number]
Claim/Reference Number: [Claim Number]
Date of Service/Requested Service: [Date]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Outpatient Treatment/Procedure] requested by my physician, [Physician Name]. The denial letter dated [Date of Letter] states that the treatment was denied due to a lack of medical necessity.

I believe this treatment is medically necessary because [briefly describe your condition and why the treatment is needed]. According to my healthcare provider, this treatment is the standard of care for my diagnosis and is essential to prevent [mention potential complications or worsening of condition].

Enclosed, please find the following supporting documentation:

- A letter of medical necessity from [Physician Name].
- Relevant clinical notes and diagnostic test results.
- Medical literature supporting the efficacy of this treatment for my condition.

Please re-evaluate this claim based on the attached clinical evidence. I look forward to your timely response regarding this matter. If you require further information, please contact me or my physician's office directly.

Sincerely,

[Your Signature]

[Your Printed Name]