[Your Name]
[Your Address]
[Your Phone Number]
[Your Email]

[Date]

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

RE: Notice of Appeal for [Patient Name]
Member ID: [ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Claim Number]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Procedure, Medication, or Service] prescribed by [Doctor's Name]. The request was denied on [Date of Denial Letter] for the reason of [Reason cited in the denial letter].

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

- **Diagnosis:** [Provide the specific medical diagnosis].
- **Clinical Evidence:** [Explain why this specific treatment is required based on your medical history].
- **Previous Treatments:** [List other treatments that were tried and failed, if applicable].
- **Risk of Delay:** [Describe what will happen to the patient's health if this treatment is not approved].

Enclosed please find a letter of support from [Doctor's Name], as well as relevant medical records and clinical guidelines that support the necessity of this care.

I request that you reconsider your decision and approve coverage for this service. I look forward to your written response within [Number] days as required by my policy.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from Physician
Medical Records
Copy of Denial Letter