

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

[Date]

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

RE: Formulary Exception Appeal for [Patient Name]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Prescribed Medication], which is currently not on the formulary for my health plan. I am requesting a formulary exception based on medical necessity as determined by my healthcare provider.

My physician, [Doctor's Name], has prescribed this medication to treat [Name of Condition]. According to my medical records, the alternative medications currently listed on the plan's formulary are not appropriate for my treatment because:

- [Reason 1: e.g., Previous failure of formulary drug A]
- [Reason 2: e.g., Contraindication or adverse reaction to formulary drug B]
- [Reason 3: e.g., Specific clinical requirement for the requested drug's formulation]

Attached to this letter, you will find a supporting Statement of Medical Necessity from my physician, along with relevant clinical documentation and my medical history regarding this condition.

I request that you review this appeal and grant an exception to provide coverage for [Name of Prescribed Medication] at the preferred brand or lowest possible cost-sharing tier. This medication is essential for managing my health and preventing further complications.

Please provide a written response regarding the status of this appeal within [Number of Days, e.g., 72 hours for urgent or 30 days for standard] days.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:

- Physician Letter of Support
- Clinical Medical Records
- Copy of Original Denial Letter