

[Your Name]  
[Your Title/Organization]  
[Date]

[Payer Name]  
[Appeals Department Address]  
[City, State, Zip Code]

**RE: Appeal of Peer-to-Peer Review Decision**

**Patient Name:** [Patient Name]  
**Date of Birth:** [DOB]  
**Member ID:** [ID Number]  
**Reference/Claim Number:** [Reference Number]  
**Date of Peer-to-Peer Call:** [Date of Call]

Dear Medical Director,

I am writing to formally appeal the denial maintained during the Peer-to-Peer review conducted on [Date] between [Your Name/Treating Physician] and [Payer Representative Name]. The requested [Treatment/Procedure/Medication] for the above-referenced patient remains medically necessary despite the initial clinical determination.

During our discussion, the following clinical justifications were provided but, in our view, were not sufficiently addressed in the final decision:

- [Clinical Point 1: List specific symptom, severity, or diagnostic result]
- [Clinical Point 2: List failure of previous conservative treatments]
- [Clinical Point 3: Reference specific clinical guidelines or peer-reviewed literature]

The patient presents with [Brief clinical summary]. Without this intervention, the patient faces an increased risk of [Complications/Functional Decline]. The requested service meets the definition of medical necessity as it is the standard of care for this specific diagnosis.

Attached please find [Supporting Documentation, e.g., imaging reports, progress notes, or clinical studies] which further substantiate the need for this request. We ask that this case be reviewed by a specialist in the field of [Specialty Name] to ensure a thorough understanding of the clinical nuances involved.

I look forward to your prompt reconsideration of this request. Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Your Signature]  
[Your Printed Name]  
[NPI Number]