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

[Date]

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

RE: Appeal for Denied Coverage
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Claim/Reference Number: [Claim Number]
Requested Treatment: [Name of Treatment/Procedure]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Treatment], which was prescribed by my physician, Dr. [Physician's Name]. The denial letter dated [Date of Denial Letter] states that the treatment was denied because it is considered "investigational" or "experimental."

My physician has determined that this treatment is medically necessary because [briefly explain your condition and why standard treatments have failed or are not appropriate]. Although labeled as investigational by your guidelines, there is significant clinical evidence and peer-reviewed data supporting its efficacy for my specific diagnosis.

Attached to this letter, please find:

- A letter of medical necessity from Dr. [Physician's Name].
- Relevant clinical studies and peer-reviewed journal articles showing the success of this treatment.
- My medical records documenting the failure of previous conventional therapies.

I request that you reconsider this denial and approve coverage for this essential treatment. Given the urgency of my medical condition, I look forward to a timely response.

Sincerely,

[Your Signature]
[Your Printed Name]