

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

[Date]

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

RE: Dosage Exception Appeal for [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for a specific dosage of [Medication Name] prescribed by my physician, [Physician Name]. The denial, received on [Date of Denial Letter], stated that the requested dosage exceeds the plan's quantity limits or standard guidelines.

My physician has determined that the standard dosage is insufficient for treating my condition: [Name of Medical Condition]. Based on my clinical history, [Medication Name] at the dosage of [Requested Dosage] is medically necessary for the following reasons:

- [Reason 1: e.g., Failure of lower doses to control symptoms]
- [Reason 2: e.g., Specific severity of the diagnosis]
- [Reason 3: e.g., Clinical trial data or specialist recommendation]

Attached to this letter, you will find a Letter of Medical Necessity from my doctor, as well as [list any other supporting documents, such as lab results or medical records].

I request that you reconsider this denial and approve the requested dosage so that I may continue my treatment plan without interruption. Please provide a written response regarding your decision within [Number] days.

Thank you for your time and prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]