

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

**[Date]**

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

**RE: Network Inadequacy Appeal**  
**Patient Name:** [Patient Full Name]  
**Member ID Number:** [Member ID]  
**Claim/Reference Number:** [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally appeal the [denial/reimbursement rate] regarding services provided by [Out-of-Network Clinic Name] on [Date of Service]. This appeal is based on the grounds of network inadequacy.

I required specialized medical care for [Specific Medical Condition]. Upon reviewing the provider directory and contacting your member services department, I found that there are no in-network clinics or providers within a reasonable distance ([Number] miles) of my home who possess the necessary expertise to treat this condition.

The decision to seek care at [Out-of-Network Clinic Name] was a medical necessity because:

- [Reason 1: e.g., In-network providers are not accepting new patients.]
- [Reason 2: e.g., In-network providers have a wait time of over 3 months.]
- [Reason 3: e.g., In-network providers do not offer the specific treatment/technology required.]

According to [State Law or Affordable Care Act] requirements, insurance carriers must maintain a network that is sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delay. Because your network failed to provide an available specialist, I am requesting that this claim be processed at the **In-Network** benefit level (including co-pays and deductibles).

Attached you will find [List attachments: e.g., doctor's referral, logs of calls to in-network providers, or medical records].

Please review this appeal and provide a written response within [Number] days. Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]