

URGENT: EXPEDITED APPEAL REQUESTED

[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Policy/Member ID Number]
[Group Number]

[Date]

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

RE: Notice of Denial for [Service/Procedure/Treatment]

Claim/Reference Number: [Reference Number]

Provider: [Out-of-Network Provider Name]

To Whom It May Concern,

I am writing to formally request an **expedited appeal** regarding the denial of coverage for [Treatment/Procedure] to be performed by [Provider Name]. I am requesting this expedited review because the standard 30-day appeal timeline would seriously jeopardize my life, health, or ability to regain maximum function.

This request is based on **medical necessity** and the lack of a qualified, available provider within your network who can provide the specific expertise required for my condition. My diagnosis is [Diagnosis Name].

Reason for Out-of-Network Necessity:

- [Detail why in-network providers are unable to treat this specific case.]
- [Detail the unique qualifications or specialized equipment offered by the out-of-network provider.]
- [Detail the immediate risks associated with delaying this treatment.]

Attached you will find a Letter of Medical Necessity from my treating physician, [Physician Name], along with relevant clinical records and peer-reviewed literature supporting this course of treatment. These documents confirm that [Provider Name] is the most appropriate provider for my specific medical needs.

Due to the urgent nature of my medical condition, I look forward to your decision within 72 hours, as required by law for expedited appeals. Please contact me immediately at [Phone Number] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures:

- Letter of Medical Necessity from Physician
- Clinical Records/Test Results
- Copy of Original Denial Letter