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

[Date]

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

RE: Second Level Appeal for Case/Reference Number: [Reference Number]
Member Name: [Patient Name]
Member ID Number: [ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

Dear Appeals Committee,

I am writing to formally request a second-level appeal regarding the denial of coverage for services provided at [Clinic Name], which is currently considered out-of-network. I received the first-level appeal denial on [Date of Denial Letter]. I disagree with this decision and am requesting a formal review by an independent committee.

The basis for this appeal is as follows:

- **Network Inadequacy:** There are no in-network providers within a reasonable distance who possess the specific expertise required to treat my condition, which is [Name of Condition].
- **Continuity of Care:** [Clinic Name] has provided ongoing specialized treatment that cannot be interrupted without significant risk to my health.
- **Medical Necessity:** My treating physician, Dr. [Doctor Name], has determined that the services at [Clinic Name] are medically necessary and that no equivalent in-network alternative exists.

Attached to this letter, please find additional supporting documentation, including:

- A detailed letter of medical necessity from my primary specialist.
- Medical records and clinical data demonstrating my response to treatment at this facility.
- A list of in-network providers contacted who were unable to provide the required care.

I request that [Insurance Company Name] grant an administrative exception to cover these services at the in-network benefit level due to these extenuating circumstances. I look forward to your response within the timeframe required by my policy and state law.

Sincerely,

[Signature]
[Typed Name]