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

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

RE: Urgent Medical Necessity Appeal

Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Procedure, Medication, or Service]. This appeal is being filed as an **Urgent Medical Necessity Exception** because a delay in receiving this treatment poses a serious threat to the patient's health and life.

The denial stated the reason for rejection was [Reason given in denial letter]. However, [Patient Name] requires this specific treatment because:

- [Reason 1: Describe why other covered alternatives failed or are contraindicated]
- [Reason 2: Describe the immediate risks of delaying this treatment]
- [Reason 3: Reference clinical guidelines or doctor's recommendations]

Attached to this letter, you will find a Letter of Medical Necessity from [Doctor's Name], as well as [list any other documents, such as clinical trials, test results, or medical records] that support the urgency of this request.

Due to the critical nature of this medical condition, I request an expedited review of this appeal. According to federal regulations, a decision for an urgent appeal must be rendered within 72 hours.

Thank you for your immediate attention to this life-sensitive matter. I look forward to your prompt response.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
- Physician Letter of Medical Necessity
- Clinical Records/Test Results
- Original Denial Letter