[Your Name]
[Your Title/Position]
[Organization/Clinic Name]
[Address]
[Phone Number]
[Email]

[Date]

[Insurance Company Name]
[Appeals Department]
[Address]

RE: Request for Peer-to-Peer Review Appeal
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Reference/Authorization Number: [Reference Number]
Requested Service/Medication: [Service Name]

To Whom It May Concern,

I am writing to formally request a Peer-to-Peer review regarding the recent denial of the medical service/medication mentioned above. I have reviewed the denial letter dated [Date of Denial] and believe that further clinical discussion is necessary to demonstrate medical necessity.

The denial stated that the request was [Reason for Denial]. However, based on the patient's clinical history, including [Brief Clinical Detail], this treatment is essential for the patient's care because [Reason for Medical Necessity].

I would like to schedule a call with a Medical Director or a peer reviewer who is board-certified in [Your Specialty]. I am available for this discussion at the following times:

- [Option 1: Date and Time Window]
- [Option 2: Date and Time Window]
- [Option 3: Date and Time Window]

Please reach me directly at [Your Direct Phone Number]. If these times do not work, please contact my office at [Office Phone Number] to coordinate a suitable time.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]
[NPI Number]