[Date]

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

**RE: Notice of Appeal for Inpatient Length of Stay Denial**

**Patient Name:** [Patient Name]
**Subscriber ID:** [ID Number]
**Claim Number:** [Claim Number]
**Date of Service:** [Start Date] to [End Date]
**Denied Days:** [Specific Dates Denied]

To Whom It May Concern,

This letter is a formal appeal regarding the denial of coverage for the inpatient hospital stay for the dates listed above. We disagree with the determination that the extended stay was not medically necessary.

The patient was admitted for [Diagnosis/Condition]. While the initial stay was approved, the requested extension for [Number] additional days was necessary due to the following clinical factors:

- [Detail 1: Lack of clinical stability/fever/abnormal vitals]
- [Detail 2: Requirement for intravenous medications or continuous monitoring]
- [Detail 3: Post-operative complications or delayed recovery]
- [Detail 4: Failed discharge planning due to safety concerns]

During the denied period, the patient required professional nursing care and physician oversight that could not be safely provided at a lower level of care. Discharge prior to [Date] would have placed the patient at high risk for readmission or adverse health outcomes.

Attached you will find supporting medical records, including physician progress notes, lab results, and nursing logs, which demonstrate the patient's ongoing need for acute inpatient care.

We request a full reversal of this denial. If you require further information, please contact [Name] at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]
[Title/Relationship to Patient]

**Enclosures:** [List attached medical documents]