

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

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

RE: Appeal of Coverage Denial for Extended Length of Stay

Patient Name: [Patient First and Last Name]
Subscriber ID: [Insurance ID Number]
Claim Number: [Reference Number]
Date of Service: [Date Range of Stay]
Facility: [Hospital Name]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for the extended hospital stay from [Start Date of Denied Period] to [End Date of Denied Period]. The denial stated that the additional days were not medically necessary; however, the extension was required due to acute post-operative complications.

The patient underwent [Name of Surgery] on [Date]. While the initial recovery was expected to follow a standard timeline, the following clinical complications occurred which mandated inpatient monitoring and intervention:

- **Complication:** [e.g., Post-operative infection, pulmonary embolism, uncontrolled hemorrhage]
- **Clinical Evidence:** [e.g., Fever of 102.5, abnormal lab results, or unstable vital signs]
- **Interventions Required:** [e.g., Intravenous antibiotics, supplemental oxygen, or emergency bedside procedure]

Because of these complications, the patient did not meet the criteria for a safe discharge to a lower level of care. Discharging the patient prematurely would have resulted in an immediate readmission and posed a significant risk to the patient's health.

Attached you will find the relevant medical records, including operative reports, progress notes, and lab results, which document the medical necessity of the extended stay. Based on this clinical documentation, I request that you overturn the initial denial and approve the claim in full.

Thank you for your prompt attention to this matter. I look forward to your response within [Number] days.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Role]