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

[Date]

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

RE: Notice of Internal Appeal
Patient Name: [Patient Full Name]
Member ID: [Member ID Number]
Claim/Reference Number: [Reference Number]
Facility: [Hospital Name]
Dates of Service: [Dates Denied]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for the continued inpatient length of stay from [Date] to [Date]. This appeal is based on the fact that discharge on the denied date would have been clinically unsafe and contrary to medical necessity standards.

At the time of the denial, the patient's clinical status remained unstable for the following reasons:

- [Reason 1: e.g., Uncontrolled pain or unstable vital signs]
- [Reason 2: e.g., Requirement for IV medications or specialized monitoring]
- [Reason 3: e.g., Inability to perform activities of daily living or lack of safe home support]

The treating physician, Dr. [Doctor's Name], determined that the patient did not meet the criteria for a safe discharge to a lower level of care. Discharging the patient prematurely would have posed a significant risk of immediate relapse, complications, or emergency readmission.

Enclosed are medical records and a letter of medical necessity from the treating provider documenting why the acute inpatient level of care was required for the duration of the stay. I request that you overturn this denial and authorize payment for all dates of service.

I look forward to your written response within the timeframe required by law. Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
[List enclosed documents, e.g., Physician Statement, Clinical Notes]