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

[Date]

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

RE: Appeal of Coverage Denial for Continued Length of Stay
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Denial Reference Number]
Provider Name: [Facility/Provider Name]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for a continued length of stay regarding intravenous (IV) therapy for [Patient Name]. We received notification on [Date of Denial] stating that the extension of care was denied because [Reason given in denial letter].

The treating physician, [Doctor's Name], has determined that continued inpatient or outpatient IV therapy is medically necessary for the treatment of [Specific Medical Condition]. The current treatment plan requires IV administration of [Name of Medication] for a duration of [Number of Days/Weeks].

Continued stay is required based on the following clinical justifications:

- [Clinical Reason 1: e.g., Patient is still febrile or showing signs of active infection]
- [Clinical Reason 2: e.g., Oral medication alternatives have failed or are not appropriate for this severity]
- [Clinical Reason 3: e.g., Requirement for professional monitoring of vital signs or infusion reactions]

Failure to complete the full course of IV therapy poses a significant risk of [Potential Risks, e.g., relapse, antibiotic resistance, or hospital readmission]. Therefore, we request that you overturn the denial and authorize the additional days requested by the medical team.

Attached please find supporting documentation, including [List attachments, e.g., clinical notes, lab results, and a letter of medical necessity from the physician].

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

Sincerely,

[Your Signature]
[Your Printed Name]