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

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

RE: Appeal of Coverage Denial for Inpatient Length of Stay

Patient Name: [Patient First and Last Name]
Patient Date of Birth: [MM/DD/YYYY]
Member ID Number: [ID Number]
Claim/Reference Number: [Reference Number]
Dates of Service: [Start Date] to [End Date]

To Whom It May Concern,

This letter is a formal appeal regarding the denial of coverage for the inpatient hospital stay for [Patient Name] from [Date] to [Date]. The denial stated that the extended stay was not medically necessary; however, the clinical documentation demonstrates that the patient required acute hospital care for the management of a severe infection (Sepsis/Bacteremia/Abscess).

During the requested period, the patient's condition required the following medical interventions that could not be safely managed in a lower level of care:

- **Intravenous (IV) Antibiotic Therapy:** Requirement for [Frequency] administration of [Antibiotic Name] and monitoring for therapeutic levels or adverse reactions.
- **Clinical Instability:** The patient exhibited [Fever / Tachycardia / Hypotension / Altered Mental Status], necessitating frequent vital sign monitoring and physician assessment.
- **Diagnostic Monitoring:** Continued need for serial lab work (CBC, Lactate, Cultures) to ensure the infection was responding to treatment.
- **Specialized Procedures:** [Mention if applicable: e.g., Incision and Drainage, Wound Care, or Imaging].

Discharging the patient earlier would have posed a significant risk of medical relapse, readmission, or permanent injury. The inpatient setting was essential to ensure the infection was stabilized and the patient was hemodynamically sound before transition to outpatient care.

Enclosed are the relevant medical records, including physician progress notes, laboratory results, and the medication administration record (MAR) for your review.

We request an immediate reversal of this denial. If you require further clinical information, please contact [Contact Name] at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name and Title]

Enclosures: [List documents, e.g., Lab Results, Physician Notes]