[Physician Name/Medical Director]

[Department Name]

[Facility/Hospital Name]

[Date]

[Insurance Company Name]

[Appeals Department Address]

[City, State, Zip Code]

RE: Appeal of Extended Length of Stay Denial

Patient Name: [Patient Name]

Date of Birth: [DOB]

Policy Number: [Policy Number]

Claim/Reference Number: [Claim Number]

Dates of Service Denied: [Dates]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for the extended hospital stay of the aforementioned patient for the dates of [Dates]. The denial cited that acute inpatient care was no longer medically necessary; however, the patient remained hospitalized during this period due to **refractory symptom control** that could not be safely managed in a lower level of care.

Despite standard interventions, the patient experienced persistent and intractable [List Symptoms, e.g., pain, nausea, dyspnea]. Previous treatment attempts including [List Medications/Treatments] failed to provide adequate stabilization. During the contested period, the patient required:

- Frequent titration of intravenous medications and continuous monitoring for adverse effects.
- Specialized intervention from the [e.g., Palliative Care/Pain Management] team.
- Ongoing assessment for life-threatening complications related to uncontrolled symptoms.

Discharge prior to achieving symptomatic stability would have posed a significant risk of immediate relapse and emergency readmission. Clinical documentation attached confirms that

the patient's condition remained unstable and required the intensity of service only available in an acute inpatient setting.

I request a review of this case by a physician peer in the same specialty. Please overturn this denial to ensure the patient receives coverage for the necessary medical care provided.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Phone Number]