

[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: Second Level Grievance Appeal**

Patient Name: [Patient Name]  
Member ID Number: [ID Number]  
Claim/Reference Number: [Claim Number]  
Date of Service: [Start Date] to [End Date]

To the Appeals Committee,

I am writing to formally request a Second Level Grievance Appeal regarding the denial of coverage for the inpatient length of stay at [Hospital Name]. I am appealing the decision upheld in the First Level Appeal dated [Date of First Denial Letter].

The denial stated that the continued stay was not "medically necessary." I strongly disagree with this assessment. During the period in question, the patient required acute inpatient care due to the following clinical reasons:

- [Reason 1: e.g., Unstable vital signs or symptoms]
- [Reason 2: e.g., Requirement for IV medications/interventions]
- [Reason 3: e.g., Risk of immediate relapse or complications if discharged]

Attached you will find additional documentation, including [mention specific records, e.g., physician notes, lab results, or a letter of medical necessity], which demonstrate that the patient did not meet the criteria for a lower level of care or safe discharge at that time.

Please conduct a full review of this case by a medical professional in the same or similar specialty as the treating physician. I look forward to your written response within the timeframe mandated by my policy and state law.

Sincerely,

[Your Signature]  
[Your Printed Name]

**Enclosures:**

[List attached medical records]

[Copy of previous denial letters]