[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Member ID Number]
[Group Number]

[Date]

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

RE: EXPEDITED URGENT APPEAL FOR PRESCRIPTION FORMULARY EXCEPTION

To Whom It May Concern:

I am writing to formally request an **expedited urgent appeal** regarding the denial of coverage for the following medication: **[Name of Medication]**. My physician, **[Doctor's Name]**, has prescribed this medication for the treatment of **[Name of Condition]**.

A standard appeal process would seriously jeopardize my life, health, or ability to regain maximum function. Therefore, I request that this appeal be processed within 72 hours.

This medication is medically necessary because:

- [List formulary medications you have tried and failed]
- [List adverse reactions to formulary medications]
- [Explain why other formulary drugs are contraindicated or ineffective for your specific case]

Attached is a letter of medical necessity from my physician and relevant clinical documentation supporting this request. Please review this information immediately to prevent a gap in my essential treatment.

Please notify me and my physician of your decision by phone or fax at [Physician Phone/Fax Number] as soon as a determination is made.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures:
Letter of Medical Necessity from [Doctor's Name]
Clinical Records/Lab Results