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

[Date]

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

RE: Appeal for Denial of Claim/Authorization

Patient Name: [Patient Full Name]
Policy Number: [Insurance Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Claim or Reference Number]
Date of Service: [Date]

Dear Appeals Department,

I am writing to formally appeal the denial of [Service/Procedure/Medication Name] which was denied due to a lack of proof of medical necessity. I believe this service is medically necessary for the treatment of my condition, [Diagnosis Name].

Attached to this letter, please find the following documentation to support the medical necessity of this request:

- A letter of medical necessity from my physician, [Doctor's Name].
- Clinical notes and diagnostic test results related to my diagnosis.
- [Optional: A list of previous treatments/medications that have failed].

According to my healthcare provider, this treatment is the standard of care for my condition because [briefly state reason, e.g., it is required to prevent further health deterioration].

I request that you reconsider your decision based on the attached clinical evidence. If you require further information, please contact me or my physician's office at [Doctor's Phone Number].

I look forward to your timely response regarding this appeal.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List attached documents]