[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 Coverage - Maximum Benefit Limit Reached**
Patient Name: [Patient Name]
Member ID Number: [Member ID]
Group Number: [Group Number]
Claim Number: [Claim Number (if applicable)]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Service/Treatment/Medication] based on the notification that I have reached my maximum benefit limit for [Current Plan Year/Lifetime].

This treatment is medically necessary for the management of my condition, [Name of Condition]. My healthcare provider, [Doctor's Name], has determined that continuing this care is essential to prevent [Describe risk of stopping treatment, e.g., significant health decline, hospitalization, or loss of mobility].

Attached to this letter, you will find a letter of medical necessity from my physician, as well as relevant medical records that document my ongoing need for these services. [Optional: Mention any specific plan language or exceptions that might apply to your case].

I request that [Insurance Company Name] grant an administrative exception or extension of benefits for this specific service to ensure I receive the life-sustaining or essential care required. My health and well-being depend on the continuation of this treatment.

Please review this appeal and provide a written response within [Number of Days, e.g., 30 days]. If you require any additional information, please contact me at [Phone Number].

Thank you for your time and reconsideration of this matter.

Sincerely,

[Signature]
[Printed Name]

**Enclosures:**
- Letter of Medical Necessity from [Doctor's Name]
- Recent Medical Records
- Copy of Denial Notice