[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: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Treatment/Service/Medication]. According to the explanation of benefits dated [Date], the claim was denied because the maximum benefit limit for this service has been reached.

I am requesting an exception to this limit based on medical necessity. This treatment is essential for the management of my condition, [Name of Diagnosis]. Discontinuing this care at this stage would likely result in [describe potential negative health outcomes, e.g., regression of progress, hospitalization, or permanent disability].

Attached to this letter, you will find supporting documentation from my healthcare provider, [Doctor's Name], which includes:

- A detailed letter of medical necessity explaining why continued treatment is vital.
- Relevant clinical notes and diagnostic test results.
- An explanation of why alternative treatments covered under the plan are not appropriate for my specific case.

Please review this additional information and reconsider the decision to deny coverage. I look forward to your response within [number of days, e.g., 30 days] as required by your grievance procedures.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Physician's Letter of Medical Necessity
Clinical Records
Copy of Original Denial Letter