[Your Name]
[Your Address]
[Your Phone Number]
[Your Email]

[Date]

[Name of Appeals Department]
[Insurance Company Name]
[Insurance Company Address]

RE: Appeal for Coverage of Continued Treatment
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for ongoing treatment regarding [Name of Chronic Condition]. I was recently notified that further benefits have been denied because I have reached the maximum benefit limit for this specific service.

My physician, [Doctor's Name], has determined that continued treatment is a medical necessity. Due to the chronic nature of my condition, ceasing treatment at this stage would lead to a significant decline in my health, increased pain, or potential hospitalization. [Briefly describe how the treatment manages your daily life or prevents complications].

I am requesting a clinical review of my case and an extension of benefits beyond the standard limit based on medical necessity. Please find attached a letter of support from my healthcare provider and relevant medical records documenting the essential nature of this ongoing care.

I look forward to your timely response regarding this urgent matter. Thank you for your reconsideration.

Sincerely,

[Your Signature]

[Your Printed Name]

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