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

[Date]

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

RE: Appeal of Coverage Denial for Ongoing Care
Patient Name: [Patient Full Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Claim Number]

To Whom It May Concern,

I am writing to formally appeal the decision to deny coverage for continued [Type of Treatment, e.g., Physical Therapy/Dialysis] sessions. According to the notice dated [Date of Denial Letter], the reason for denial is that I have reached the maximum benefit limit for this service.

I am requesting a clinical review and an extension of these benefits based on medical necessity. My healthcare provider, Dr. [Provider Name], has determined that interrupting my current care plan would result in a significant regression of my health status and [mention specific risk, e.g., loss of mobility/organ failure].

Attached to this letter, please find:

- A Letter of Medical Necessity from my treating physician.
- Current clinical progress notes documenting the efficacy of the treatment.
- A detailed care plan outlining the remaining duration of necessary treatment.

Due to the critical nature of this ongoing treatment, I request an expedited review of this appeal. Please notify me of your decision in writing within [Number] days.

Thank you for your immediate attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]