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

[Date]

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

RE: Urgent Appeal for Coverage Extension
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim Number: [Claim Number, if applicable]

Dear Appeals Committee,

I am writing to formally appeal the denial of further coverage for my life-saving medical treatment, [Name of Treatment/Procedure]. I have been informed that coverage has been terminated because I have reached the maximum benefit limit under my current plan.

I am requesting an immediate administrative override and extension of benefits based on medical necessity. My treating physician, Dr. [Physician Name], has determined that this treatment is essential to sustain my life. Stopping or delaying this care would result in [describe immediate life-threatening consequences or severe permanent disability].

The Affordable Care Act (ACA) prohibits annual and lifetime dollar limits on most essential health benefits. I believe this limit is in violation of these protections or fails to account for the extraordinary circumstances of my life-threatening condition.

Attached to this letter, please find:

- A letter of medical necessity from my specialist outlining why this treatment is vital.
- Relevant medical records and diagnostic results.
- Detailed documentation of the life-threatening risks associated with a cessation of care.

Due to the critical nature of my health, I request an expedited review of this appeal. I look forward to your prompt response within [24/48/72] hours regarding the continuation of my life-saving care.

Sincerely,

[Your Signature]
[Your Printed Name]