head>

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

[Date]

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

RE: Appeal for Coverage of Diagnostic Testing
Patient Name: [Patient 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 denial of coverage for [Name of Diagnostic Test] performed or scheduled on [Date]. The denial notice states that the maximum benefit limit for this type of service has been reached.

I am requesting a clinical review of this case based on medical necessity. This specific diagnostic test is essential for the ongoing management and treatment of my condition, [Name of Condition]. My healthcare provider, [Doctor's Name], has determined that this test is required to [reason for test: e.g., monitor disease progression, evaluate the effectiveness of current treatment, or rule out complications].

Without this diagnostic information, there is a significant risk of [mention potential health risks or delayed treatment]. This test is not elective; it is a critical component of my standard of care. I have included a letter of medical necessity from my physician and relevant clinical documentation to support this request.

I ask that you grant an exception to the benefit limit in this instance to ensure I receive the necessary care mandated by my medical team. Please review this appeal and provide a written response within [Number] days.

Thank you for your time and consideration of this urgent matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from [Doctor's Name]
Relevant Medical Records
Original Denial Notice