[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Insurance Policy/Member ID Number]

[Date]

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

RE: EXPEDITED APPEAL FOR URGENT/LIFE-SAVING MEDICAL TREATMENT

Patient Name: [Patient Name]

Claim/Reference Number: [Number from Denial Letter]

Requested Treatment/Medication: [Name of Treatment]

To Whom It May Concern,

I am writing to formally request an **Expedited Appeal** of the denial for [Name of Treatment/Procedure]. This request is being made because the standard 30-day appeal timeframe would seriously jeopardize the patient's life, health, and ability to regain maximum function.

The requested treatment is medically necessary and life-saving for the following reasons:

- **Diagnosis:** [Detailed description of the life-threatening condition].
- **Urgency:** [Explain why delay will cause irreparable harm or death].
- **Clinical Justification:** [List why this specific treatment is the only viable option and mention attached doctor's notes].

Attached to this letter is a "Certification of Medical Necessity for Expedited Appeal" signed by my physician, [Doctor's Name], which confirms that this case meets the criteria for an urgent 72-hour review.

Please review this appeal immediately. We look forward to your response within 72 hours as mandated by law for expedited medical reviews.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
- Physician's Letter of Medical Necessity
- Medical Records/Test Results
- Copy of Original Denial Letter