[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Insurance Member ID Number]
[Case/Reference Number from Denial Letter]

[Date]

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

Subject: URGENT: Expedited Appeal for [Name of Medication]

To the Appeals Department,

I am writing to formally request an **expedited appeal** regarding the denial of coverage for [Name of Medication]. I received notice of this denial on [Date of Denial Letter].

My physician, [Doctor's Name], has determined that this medication is medically necessary for the treatment of my condition, [Diagnosis]. Due to the critical nature of my health status, a standard 30-day appeal timeframe would seriously jeopardize my life, health, or ability to regain maximum function.

Reason for Medical Necessity:

- [Briefly state why other preferred drugs failed or are contraindicated].
- [Briefly state the immediate risks of delaying this specific treatment].

Attached to this letter is a Statement of Medical Necessity and supporting documentation from my healthcare provider. Because this is a life-critical request, I am requesting a decision within 72 hours as mandated by federal law for expedited appeals.

Please contact me immediately at [Phone Number] or my physician at [Doctor's Phone Number] with your decision.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Copy of Denial Letter
Physician's Letter of Medical Necessity
Relevant Clinical Records