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

[Date]

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

RE: URGENT EXPEDITED APPEAL
Patient Name: [Child's Full Name]
Patient Date of Birth: [DOB]
Member ID Number: [ID Number]
Group Number: [Group Number]
Reference/Claim Number: [Denial Reference Number]

To Whom It May Concern,

I am writing to formally request an **Expedited Appeal** of the recent denial for [Name of Procedure/Medication/Treatment] prescribed for my child, [Child's Name]. This appeal is urgent as a delay in treatment poses a significant threat to my child's health and development.

The denial was based on [Reason stated in denial letter]. However, [Child's Name] requires this specific care because [Briefly describe the medical necessity and why alternatives are not appropriate].

According to [Physician's Name], the treating specialist, this request meets the criteria for an expedited review because the standard 30-day appeal timeframe could seriously jeopardize the life or health of my child or their ability to regain maximum function.

Attached you will find:
- A letter of medical necessity from [Physician's Name].
- Clinical notes and diagnostic results supporting the urgency.
- [Any other supporting documentation].

Due to the urgent pediatric nature of this request, I look forward to your decision within 72 hours, as required by federal law for expedited appeals.

Sincerely,

[Your Signature]

[Your Printed Name]
[Relationship to Patient]