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

[Date]

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

RE: URGENT EXPEDITED APPEAL for [Patient Name]
Reference Number: [Authorization Denial Reference Number]
Requested Procedure: [Name of Cardiac Procedure]
Provider: [Doctor's Name / Hospital Name]

To the Appeals Department,

I am writing to formally request an **expedited appeal** regarding the denial of coverage for the cardiac procedure mentioned above. My physician, [Doctor's Name], has determined that this procedure is medically necessary and urgent.

Under the Affordable Care Act and federal regulations, I am requesting an **expedited 72-hour review** because a standard 30-day appeal timeline would seriously jeopardize my life, health, and ability to regain maximum function. My current cardiac condition involves [briefly list symptoms, e.g., severe blockage, unstable angina, heart failure], which puts me at immediate risk for a cardiac event.

Attached to this letter, please find:

- A letter of medical necessity from my cardiologist.
- Clinical notes and diagnostic results (EKG, stress test, or imaging).
- A formal statement from my doctor confirming that the standard appeal timeframe is life-threatening.

Please review this request immediately. You may contact my physician at [Doctor's Phone Number] or reach me directly at [Your Phone Number] with your decision. I look forward to your prompt response within the 72-hour expedited window.

Sincerely,

[Your Signature]
[Your Printed Name]