[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Health Plan ID Number]

[Date]

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

RE: URGENT EXPEDITED APPEAL
Patient Name: [Patient Name]
Claim/Reference Number: [Reference Number]
Date of Service/Request: [Date]
Provider Name: [Physician Name]

To the Appeals Department,

I am writing to formally request an **Expedited Appeal** of the denial for acute pain management services/medication requested by my physician. I am requesting an expedited review because the standard 30-day appeal timeframe could seriously jeopardize my health and ability to regain maximum function.

I am currently experiencing acute, severe pain that is not managed by current treatments. My physician, [Doctor's Name], has determined that the denied service is medically necessary to prevent further physical complications and to manage debilitating symptoms. Delaying this treatment will result in [mention specific consequences, e.g., emergency room visits, loss of mobility, or severe physical distress].

The denial stated [Reason for Denial from Letter]. However, this treatment is necessary because [briefly state why it is needed, e.g., previous treatments failed, or it is the standard of care for this condition].

Please find attached a letter of medical necessity from my physician and relevant medical records supporting this urgent request. Under federal law, I am entitled to a decision on this expedited appeal within 72 hours.

Thank you for your immediate attention to this urgent matter.

Sincerely,

[Your Signature]
[Your Printed Name]