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

[Date]

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

RE: First Level Appeal for [Patient Name]
Member ID: [Your Member ID Number]
Claim/Reference Number: [Reference Number from Denial Letter]
Date of Denial: [Date on Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for a [Specific Model/Type of Wheelchair], as prescribed by my physician, [Physician Name]. The reason provided for the denial was [Reason from Denial Letter, e.g., "Not Medically Necessary"].

I believe this equipment is medically necessary because [Provide brief explanation of why you need the wheelchair, e.g., inability to ambulate independently, safety risks, or failure of other mobility aids]. Without this specific wheelchair, my ability to perform Activities of Daily Living (ADLs) is severely restricted.

Enclosed, please find the following supporting documentation:

- A Letter of Medical Necessity from [Physician Name].
- Physical/Occupational Therapy evaluation reports.
- Relevant medical records detailing my diagnosis and mobility limitations.
- Technical specifications for the requested wheelchair.

I request that you reconsider this claim based on the attached clinical evidence. If you require further information, please contact me at [Your Phone Number] or my physician's office at [Physician's Phone Number].

Thank you for your prompt attention to this matter. I look forward to your response within the timeframe required by my policy.

Sincerely,

[Your Signature]

[Your Printed Name]