[Physician Name, MD/DO]

[Practice/Facility Name]

[Address]

[City, State, Zip Code]

[Phone Number]

[Date]

[Insurance Company Name]

[Appeals Department Address]

[City, State, Zip Code]

RE: Appeal for Orthopedic Brace Coverage

Patient Name: [Patient Name]

Date of Birth: [DOB]

Policy Number: [Policy ID]

Claim/Reference Number: [Claim Number]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for a [Brand/Model of Orthopedic Brace], HCPCS code [Insert Code]. This device was prescribed to treat [Patient Name] for [Diagnosis/ICD-10 Code].

The patient presents with [List symptoms, e.g., chronic instability, severe pain, loss of mobility]. Clinical evaluation confirms [Results of physical exam or imaging]. Without this specific orthopedic brace, the patient is at high risk for [List risks, e.g., further injury, surgical intervention, falls].

The following conservative treatments have been attempted and failed:

- [Treatment 1: e.g., Physical Therapy for X weeks]
- [Treatment 2: e.g., NSAIDs/Injections]
- [Treatment 3: e.g., Over-the-counter bracing]

This custom/specialized brace is medically necessary to provide the stabilization required for the patient to [Goal, e.g., perform activities of daily living/return to work]. A standard off-the-shelf brace is insufficient because [Reason, e.g., unique anatomy, specific corrective force needed].

I request that you reconsider your decision and approve coverage for this essential medical equipment. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]