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

[Date]

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

RE: Notice of Denial Appeal
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for a semi-electric hospital bed, as requested by my physician, [Physician Name]. This request was denied on [Date of Denial Letter] based on the determination that [Reason for Denial from Letter].

I believe this equipment is medically necessary for the following reasons:

- **Medical Condition:** I have been diagnosed with [Diagnosis/Condition], which requires [specific positioning, e.g., elevation of the head/feet] to alleviate [specific symptom, e.g., severe respiratory distress or chronic pain].
- **Functional Limitations:** My condition prevents me from [e.g., safely transferring in and out of a standard bed or adjusting positions independently], which increases the risk of [e.g., falls or pressure ulcers].
- **Physician Recommendation:** My treating physician has determined that a standard bed is insufficient for my medical management and that a hospital bed is required to [e.g., facilitate nursing care or prevent aspiration].

Attached to this letter, please find a Letter of Medical Necessity from my physician, clinical notes regarding my mobility limitations, and [list any other attachments like photos or test results].

I request that you reconsider this denial and approve the coverage for this essential medical equipment. I look forward to your written response within the time frame mandated by my policy.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
- Letter of Medical Necessity from [Physician Name]
- Clinical Progress Notes
- Copy of Original Denial Letter