Date: [Insert Date]

To: [Medical Director Name/Appeals Department]
Insurance Company: [Health Plan Name]
Address: [Insurance Address]

Re: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID: [Member ID Number]
Reference/Claim Number: [Reference Number]
Requested Device: [Device Name/Model]

Dear Medical Director,

I am writing to formally appeal the denial of the aforementioned medical device following the Peer-to-Peer review held on [Date of Conversation] between [Physician Name] and [Insurance Reviewer Name]. During that discussion, the request for [Device Name] was maintained as denied based on [State Reason for Denial]. We strongly disagree with this determination.

The use of [Device Name] is medically necessary for this patient due to the following clinical factors:

- **Clinical Diagnosis:** [Briefly describe the patient's condition and severity].
- **Previous Treatments:** [List medications, therapies, or lower-tier devices that failed].
- **Expected Outcome:** [Explain how this specific device prevents hospitalization, surgery, or permanent disability].

The Peer-to-Peer discussion did not fully account for [mention specific clinical data or guideline omitted during the call]. Per the [Mention specific medical society guidelines], this device is the standard of care for patients who present with [Patient's specific symptoms].

Attached please find supporting documentation, including updated clinical notes, relevant peer-reviewed literature, and the original prescription. We request an immediate reconsideration of this denial to ensure the patient receives timely and essential medical intervention.

I look forward to your prompt response regarding this matter.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Facility Name]
[Phone Number]