[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Administrative Appeal for Durable Medical Equipment (DME)

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID Number: [ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Claim Number]
Equipment Requested: [Name of Equipment/Device]

To Whom It May Concern,

This letter serves as a formal administrative appeal regarding the denial of coverage for the medical equipment listed above. Our records indicate that the request was denied on [Date of Denial] for the following reason: [State reason from denial letter, e.g., lack of medical necessity/experimental].

As the treating provider, we have determined that this equipment is medically necessary for the management of the patient's condition, specifically [Diagnosis/ICD-10 Code]. The patient requires this equipment because [Briefly state clinical reason, e.g., failure of previous treatments or risk of injury].

Attached to this appeal, please find the following supporting documentation:

- Letter of Medical Necessity (LMN)
- Relevant clinical progress notes
- Prescription/Physician's Order
- [List any peer-reviewed literature or specific test results]

We request an immediate review of this claim and a reversal of the prior determination. If you require further clinical information, please contact our administrative office at [Phone Number].

Sincerely,

[Physician/Provider Name]
[Title]
[NPI Number]