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

[Date]

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

RE: Final Level Appeal for Claim/Reference Number: [Insert Number]

To the Appeals Committee,

This letter serves as my formal final step grievance appeal regarding the denial of coverage for custom orthotic devices prescribed by my physician, [Doctor's Name]. I am requesting an immediate reversal of your previous decision to uphold the denial dated [Date of Denial Letter].

My medical provider has determined that these custom orthotics are a medical necessity to treat [Specific Diagnosis/Condition, e.g., severe plantar fasciitis, structural foot deformity, or diabetic complications]. Over-the-counter inserts have proven ineffective, and without these custom devices, I am at risk for [mention risks, e.g., further injury, loss of mobility, or surgery].

Please find the following documentation attached to support this final appeal:

- A Letter of Medical Necessity from my specialist.
- Clinical notes detailing my diagnosis and previous failed treatments.
- Relevant gait analysis or imaging results.
- Specific details on how the requested device meets the criteria outlined in my policy.

I have exhausted the internal grievance process and am prepared to take this matter to an External Independent Review Board if this final appeal is not granted. I look forward to your prompt response within the legally required timeframe.

Sincerely,

[Your Signature]

[Your Printed Name]