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

[Date]

[Name of Medical Director/Appeals Department]
[Insurance Company Name]
[Address]
[City, State, Zip Code]

RE: Appeal of Coverage Denial for Ventilator
Patient Name: [Patient Full Name]
Policy Number: [Insurance ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Denial Reference Number]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for a [Brand and Model of Ventilator], as prescribed by [Physician Name]. The denial letter dated [Date of Denial] stated that the request was denied due to "insufficient clinical information."

Attached to this letter is a comprehensive clinical package intended to address the documentation gaps cited. This package includes:

- **Letter of Medical Necessity:** A detailed statement from [Physician Name] outlining the patient's diagnosis of [Specific Diagnosis, e.g., Chronic Respiratory Failure/Neuromuscular Disease].
- **Clinical Evaluation:** Recent physical assessment notes and respiratory evaluations.
- **Pulmonary Function Tests:** Recent ABG (Arterial Blood Gas) results, nocturnal oximetry, or capnography data showing [CO2 levels/oxygen desaturation].
- **Treatment History:** Documentation showing that less invasive therapies (such as CPAP or BiPAP) have been tried and failed, or are clinically inappropriate for this patient's condition.
- **Device Settings:** Specific physician-ordered settings required to maintain the patient's respiratory stability.

The requested ventilator is not for elective use; it is a life-sustaining medical device required to prevent [Emergency Room visits/hospitalizations/respiratory arrest]. The clinical data provided demonstrates that the patient meets all necessary criteria for this equipment.

Please review this additional information and reconsider the coverage for this essential medical equipment. I look forward to your written response within [Number of Days, e.g., 15] days.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Physician Letter of Medical Necessity
Clinical Test Results
Prescription/Order Forms