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

[Date]

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

**RE: Second-Level Formal Appeal for Denial Sustained**

**Patient Name:** [Patient Name]
**Member ID:** [Member ID Number]
**Date of Birth:** [DOB]
**Claim Number:** [Claim Number]
**Date of Service:** [Date of Service]
**Total Billed Amount:** $[Amount]

Dear Appeals Committee,

This letter serves as a formal second-level appeal regarding the sustained denial of the above-referenced claim. We have reviewed your previous denial notification dated [Date of First Appeal Denial], which cited [Reason for Denial, e.g., Lack of Medical Necessity]. We strongly disagree with this determination.

The requested [Procedure/Treatment/Medication] is medically necessary for this patient due to the following reasons:

- [Detailed Clinical Justification 1]
- [Detailed Clinical Justification 2]
- [Reference to specific failed treatments or conservative therapies]

Please find the enclosed additional documentation to support this appeal, including [List documents, e.g., updated physician notes, peer-reviewed journal articles, or diagnostic images]. These records demonstrate that the patient meets the criteria outlined in your clinical policy [Policy Number, if known].

We request that a physician of the same specialty review this case to ensure a fair clinical assessment. We look forward to your prompt reconsideration and a written response within [Number] days.

Sincerely,

[Provider Signature]
[Provider Name, Title]
[Clinic Name]

**Enclosures:**
[List of supporting documents]