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

[Date]

[Name of Appeals Committee/Contact Person]
[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Second-Level Appeal for Claim Denial
Patient Name: [Patient Name]
Member ID: [Member ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Clinic Name: [Clinic Name]

Dear Appeals Committee,

This letter serves as a formal second-level appeal regarding the sustained denial of the claim mentioned above. I am requesting a full reconsideration of your previous decisions based on the additional information and clinical evidence provided herein.

The claim was previously denied for [Reason for Denial, e.g., Medical Necessity/Experimental Treatment/Out of Network]. However, I believe this service should be covered because:

- [Reason 1: Detail why the service was medically necessary]
- [Reason 2: Reference specific plan benefits or prior authorizations]
- [Reason 3: Note any errors in the previous review or processing]

Enclosed, please find supporting documentation to assist in your review, including:

- [List document 1: e.g., Letter of Medical Necessity from Doctor]
- [List document 2: e.g., Clinical notes or diagnostic test results]
- [List document 3: e.g., Copies of previous appeal correspondence]

I request that a different medical reviewer or an independent third party review this file, as is my right under the second-level appeal process. I look forward to your timely response regarding this matter within [Number of days, e.g., 30] days as per policy guidelines.

Thank you for your time and reconsideration.

Sincerely,

[Your Signature]

[Your Printed Name]