

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

[Date]

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

RE: Second-Level Formal Appeal for [Patient Name]

Member ID: [ID Number]

Group Number: [Group Number]

Claim/Reference Number: [Reference Number]

Date of Service: [Date]

To the Appeals Committee,

This letter serves as a formal second-level appeal regarding the sustained denial of coverage for [Name of Procedure, Medication, or Service]. We received the first-level appeal denial dated [Date of Denial Letter], which stated that the request was denied because [State reason given by insurance company].

We strongly disagree with this decision. I am submitting additional documentation to demonstrate that this treatment is medically necessary and meets the criteria for coverage under my policy. This appeal includes:

- A detailed letter of medical necessity from my treating physician, [Doctor's Name].
- Clinical peer-reviewed literature supporting the efficacy of this treatment for my specific condition.
- Relevant medical records and diagnostic results (attached).
- A summary of previous treatments that have been unsuccessful.

[Insert 1-2 paragraphs here describing why the previous denial was incorrect and how the requested service is the standard of care for the patient's specific diagnosis].

I request that a board-certified specialist in [Medical Specialty] who was not involved in the initial or first-level denial review this case. The delay in receiving this necessary care is negatively impacting my health and quality of life.

Please provide a written response within the timeframe mandated by state and federal law. Thank you for your immediate attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures: [List attached documents]