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

[Date]

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

RE: Second-Level Appeal / Formal Reconsideration Request
Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number]
Date of Initial Denial: [Date]
Date of First-Level Appeal Denial: [Date]

To the Appeals Review Committee,

I am writing to formally request a second-level reconsideration of the sustained denial for [Name of Procedure/Medication/Service]. I received the notification dated [Date] upholding the initial denial, and I strongly disagree with this decision.

The denial stated that the requested service was [Reason for Denial, e.g., Not Medically Necessary / Experimental]. However, I believe this service is vital for my health for the following reasons:

- [Reason 1: Describe how previous treatments have failed.]
- [Reason 2: Reference specific clinical guidelines or doctor recommendations.]
- [Reason 3: Explain the potential health risks if this service is not provided.]

Enclosed, please find additional documentation to support this appeal, including:

- A formal letter of medical necessity from my treating physician, Dr. [Doctor's Name].
- Relevant clinical notes and diagnostic test results.
- [List any other supporting peer-reviewed literature or records].

I request that this appeal be reviewed by a board-certified physician in the specialty of [Specialty Name] who was not involved in the first-level denial. I look forward to your prompt response regarding this matter.

Sincerely,

[Your Signature]
[Your Printed Name]