

[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 of Denial for [Patient Name]
Member ID: [ID Number]
Group Number: [Group Number]
Claim Number: [Claim Number]
Date of Service: [Date]
Reference Number of First Appeal Denial: [Reference Number]

To the Appeals Committee,

I am writing to formally request a second-level appeal regarding the denial of coverage for the medical services provided at [Clinic Name] on [Date]. The first-level appeal was denied on [Date of denial letter] for the reason of [Reason cited in the first denial letter].

I strongly disagree with this decision. I am providing additional evidence and documentation to demonstrate that these services were medically necessary and meet the criteria for coverage under my plan.

[Detailed explanation of why the service was necessary. Mention specific symptoms, previous treatments that failed, and how this specific clinic visit was essential for your health management.]

Enclosed please find the following supporting documents:

- A letter of medical necessity from my treating physician, [Doctor's Name].
- Clinical notes and diagnostic reports from the visit.
- Peer-reviewed medical literature supporting this treatment/consultation.
- Copies of previous related claims that were successfully paid.

I request that an independent medical professional, who was not involved in the first-level denial, review this case. Please provide a written response within the timeframe required by my policy and applicable laws.

Thank you for your time and reconsideration of this claim.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures: [List of attached documents]