

[Your Name/Department]
[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Payer Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Second-Level Appeal for Sustained Denial

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

To the 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 rationale dated [Date of First Appeal Denial Letter] stating [Reason for Denial]. We respectfully disagree with this decision.

The services provided were medically necessary and appropriate for the following reasons:

- [Explain clinical justification or medical necessity here]
- [Reference specific documentation or guidelines attached]
- [Address the specific reason why the first appeal was denied]

Attached you will find the following supporting documentation for your reconsideration:

- Provider progress notes and clinical records
- Original claim and first-level appeal correspondence
- [Any additional evidence like lab results or imaging]

We request that you perform a secondary clinical review of this case by a specialist in this field of medicine. Please overturn the prior denial and process this claim for full payment according to our provider agreement.

Thank you for your prompt attention to this matter. We look forward to your response within [Number] business days.

Sincerely,

[Signature]
[Printed Name]
[Title/Credential]