

[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,

I am writing to formally request a second-level appeal regarding the sustained denial of [Name of Procedure/Medication/Service]. This appeal follows the initial denial dated [Date of First Denial] and the subsequent first-level appeal denial dated [Date of Second Denial].

The previous denial stated that the requested service was not "medically necessary." I strongly disagree with this assessment. Enclosed with this letter, please find additional documentation that further clarifies the clinical necessity of this treatment, including:

- A detailed letter of medical necessity from my treating physician, [Doctor's Name].
- Clinical notes and diagnostic results (MRI, Lab reports, etc.) demonstrating why alternative treatments are insufficient.
- Peer-reviewed medical literature supporting the use of this treatment for my specific diagnosis.
- [List any other relevant documents].

My physician has determined that [Name of Service] is the standard of care for my condition and is essential to prevent [mention potential complications or decline in health]. I request that this case be reviewed by a board-certified specialist in [Medical Specialty] who is independent of the previous review cycles.

Please provide a written response within the timeframe mandated by my policy. If you require further information, please contact me directly at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
[List of enclosed documents]