[Clinic Name]
[Billing Department Address]
[City, State, Zip Code]
[Phone Number]
[Tax ID Number]

[Date]

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

RE: Second-Level Formal Appeal / Dispute of Sustained Denial

Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Policy Number: [Policy ID]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Total Amount Disputed: $[Amount]

To Whom It May Concern,

This letter serves as a formal second-level appeal regarding the denial of the above-referenced claim. We previously submitted a first-level dispute on [Date of First Appeal], which was sustained by your organization on [Date of Denial Notice] for the following reason: [State Reason Given, e.g., Medical Necessity, Experimental, Global Period].

We strongly disagree with the decision to uphold this denial. We are providing the following additional information and clinical documentation to demonstrate why this service should be covered under the patient's plan benefits:

- [Point 1: Reference specific clinical guidelines or peer-reviewed literature]
- [Point 2: Address the specific reason for the first-level denial]
- [Point 3: Clarify any coding or modifier usage if applicable]

Enclosed, please find:

- Provider's Letter of Medical Necessity
- Relevant Progress Notes and Diagnostic Reports
- Copy of the First-Level Denial Letter
- [Any other supporting documentation]

We request an independent review of this file by a medical director or specialist in this field. Please re-evaluate the submitted evidence and process this claim for payment immediately.

We look forward to a written response regarding your decision within [15/30] days. Should you require further information, please contact [Contact Name] at [Phone Number].

Sincerely,

[Signature]
[Name of Provider or Billing Manager]
[Title]