

[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 Sustained Claim Denial

Patient Name: [Patient Name]
Policy Number: [Policy Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Reference Number for First Appeal: [Reference Number]

Dear Appeals Committee,

I am writing to formally request a second-level appeal regarding the sustained denial of coverage for outpatient services provided on [Date of Service] at [Facility Name]. My first appeal was denied on [Date of First Denial Letter] based on the determination that [Reason provided in the first denial letter, e.g., medical necessity/out-of-network].

I disagree with this decision and request a review by a medical professional in the same specialty as the treating provider who was not involved in the initial or first-level denial. The requested outpatient treatment was medically necessary because [Provide brief clinical explanation or mention attached doctor's letter].

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

- A detailed Letter of Medical Necessity from my treating physician, [Doctor's Name].
- Relevant clinical progress notes and diagnostic results.
- [Optional: Copies of previous authorizations or relevant medical literature].

This treatment is a covered benefit under my policy guidelines, and the denial significantly impacts my continuity of care. Please review the attached evidence and reconsider your decision to sustain this denial.

I look forward to your written response within the timeframe required by state law and my policy guidelines. If you require further information, please contact me at [Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]