[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Name of External Review Organization/Appellate Body]
[Address]
[City, State, Zip Code]

RE: External Review Request for [Insured Name]
Claim Number: [Claim Number]
Reference/Case Number: [Reference Number]
Date of Adverse Determination: [Date of Denial Letter]

To the External Review Committee,

I am writing to formally request an external review of the denial of [mention the specific treatment, surgery, or benefit] by [Insurance Company Name]. I am appealing this decision on the grounds that the Independent Medical Examination (IME) conducted by [Doctor's Name] on [Date of IME] was biased, medically inaccurate, and failed to consider the full scope of my medical history.

I believe the IME findings are flawed for the following reasons:

- **Lack of Specialization:** The IME physician lacks the necessary expertise in [Specific Medical Specialty] required to accurately assess my condition.
- **Incomplete Evaluation:** The physical examination lasted only [Number] minutes and the physician failed to perform [Specific Tests] or review [Specific Medical Records/Imaging].
- **Factual Inaccuracies:** The IME report contains significant errors regarding my symptoms and history, specifically [Detail Error 1] and [Detail Error 2].
- **Disregard for Treating Physician Data:** The report ignores the long-term clinical findings and objective evidence provided by my primary treating physician, [Treating Doctor's Name].

Enclosed please find supporting documentation, including a rebuttal letter from my treating physician, objective diagnostic results (MRI/CT scans), and clinical notes that contradict the IME findings. These documents demonstrate that the requested [treatment/benefit] is medically necessary under standard clinical guidelines.

I request that a truly independent reviewer with expertise in [Medical Specialty] examine my complete file and overturn the previous denial. Thank you for your time and fair consideration of this appeal.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures:
1. Rebuttal letter from treating physician
2. Medical records and diagnostic reports
3. Copy of the initial denial and internal appeal denial