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

[Date]

[Name of External Review Organization/Insurance Appeals Department]
[Address]
[City, State, Zip Code]

RE: External Review Appeal for [Your Name]
Claim Number: [Number]
Policy Number: [Number]
Date of Adverse Determination: [Date]

To Whom It May Concern,

I am writing to formally appeal the denial of [treatment/medication/procedure] for the management of my chronic pain. This appeal is based on the findings of an Independent Medical Examination (IME) conducted on [Date] by [Doctor's Name], which I believe does not accurately reflect my clinical status or functional limitations.

I request an external review because the IME failed to consider the following:

- **Clinical History:** My chronic pain is documented over [number] years, supported by diagnostic imaging and specialist evaluations.
- **Incomplete Examination:** The IME physician only spent [number] minutes evaluating me and failed to perform [specific physical tests].
- **Treatment Consistency:** My treating physician, [Treating Doctor's Name], has determined that the requested care is medically necessary according to evidence-based guidelines.
- **Functional Impact:** The IME report overlooks the objective evidence of my inability to perform activities of daily living.

Enclosed please find supporting documentation, including a rebuttal letter from my treating physician, recent medical records, and [list any other documents]. These records demonstrate that the proposed treatment is the most appropriate and medically necessary course of action for my condition.

I look forward to a timely review of this appeal. Please notify me in writing of your final determination.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures: [List documents attached]