

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

[Date]

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

RE: Formal External Appeal of Adverse Benefit Determination

Patient Name: [Patient Name]

Claim Number: [Claim Number]

Policy Number: [Policy Number]

Date of Denial Letter: [Date]

To the Appeals Committee,

I am writing to formally request an external review of the denial of coverage for [Name of Treatment/Procedure/Service]. This appeal is based on my contention that the conclusions reached in the Independent Medical Examination (IME) conducted by [Name of IME Doctor] on [Date] are inaccurate and do not reflect my actual clinical condition or medical necessity.

I am contesting the IME findings for the following reasons:

- **Conflict with Treating Physician:** My primary treating physician, [Doctor's Name], who has managed my care for [Duration], has determined that this treatment is medically necessary based on long-term observation.
- **Incomplete Examination:** The IME physician spent only [Number] minutes evaluating me and failed to perform necessary physical tests such as [List Tests].
- **Omitted Medical Records:** The IME report fails to acknowledge significant diagnostic evidence, specifically [List MRI/CT/Lab results], which confirm my diagnosis.
- **Incorrect Clinical Conclusions:** The IME report states [Quote Incorrect Statement], which contradicts the clinical findings of [Reference Supporting Evidence].

Attached to this letter, please find supporting documentation, including a rebuttal letter from my treating physician, recent diagnostic imaging results, and my complete medical history relevant to this claim.

I request that an independent physician with expertise in [Specific Medical Specialty] review my full medical record to overturn the previous denial. I look forward to your timely response regarding this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:

- Letter of Medical Necessity from Treating Physician
- Diagnostic Test Results (Dated: [Dates])
- Clinical Progress Notes
- Copy of Initial Denial Letter