[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: Letter of Appeal for [Patient Name]
Member ID: [Member ID Number]
Claim/Reference Number: [Reference Number]
Date of Service/Request: [Date]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for the diagnostic imaging procedure [Name of Procedure, e.g., MRI/PET Scan] ordered by [Physician Name]. According to the denial letter dated [Date], the request was denied because [Reason for Denial].

I am requesting a medical necessity exception for this imaging based on the following clinical factors:

- **Patient Diagnosis:** [Enter diagnosis and ICD-10 code if known].
- **Clinical Justification:** [Describe why this specific scan is required over standard covered alternatives].
- **Previous Treatments:** [List medications, physical therapy, or other scans that have failed to provide a diagnosis or relief].
- **Urgency:** [Describe the risk of delay in diagnosis or treatment].

The requested imaging is the gold standard for evaluating [Condition] and is essential for developing an accurate treatment plan. Attached you will find supporting documentation, including clinical notes, previous test results, and a letter of support from my treating physician.

Please review this appeal and the attached medical records. I look forward to a written response regarding your decision within [Number] days. If you require further information, please contact my physician's office at [Physician Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
- Physician Letter of Medical Necessity
- Relevant Medical Records/Lab Results
- Original Denial Letter