[Provider Name]
[Provider Tax ID]
[Provider Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Appeals Department]
[P.O. Box / Address]
[City, State, Zip Code]

RE: Formal Appeal for Coverage Exception
Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Member ID Number: [ID Number]
Claim/Reference Number: [Reference Number]
Date of Service/Requested Service: [Date]

To Whom It May Concern:

I am writing to formally appeal the denial of coverage for [Treatment/Procedure Name], which has been categorized as "experimental" or "investigational." I am requesting a medical necessity exception for my patient, [Patient Name].

Clinical Background:
The patient has been diagnosed with [Diagnosis/ICD-10 Code]. To date, we have attempted the following standard treatments with no success: [List previous medications or procedures]. Due to [Specific Clinical Reason], the patient is no longer a candidate for standard protocols.

Rationale for Exception:
While this treatment is classified as experimental by your current policy, it is medically necessary for this patient because:

- [Reason 1: Peer-reviewed evidence or clinical trial data]
- [Reason 2: Lack of alternative treatments]
- [Reason 3: Expected clinical outcome/improvement]

Attached you will find [List attachments: medical records, journal articles, or clinical data] supporting the use of this treatment for this specific case. Based on the patient's unique clinical status, I urge you to overturn the initial denial and approve this request.

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] if you require additional information.

Sincerely,

[Physician Signature]
[Physician Name, Title]