[Your Name/Physician Name]
[Medical Practice/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attn: Medical Review/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Request for Peer-to-Peer Review and Appeal for Non-Covered Therapy Exception

Patient Name: [Patient Name]
Patient DOB: [DOB]
Member ID: [Member ID Number]
Reference/Claim Number: [Reference Number]

To the Medical Director,

I am writing to formally appeal the denial of coverage for [Name of Therapy/Treatment] for the above-mentioned patient. This letter also serves as a formal request for a Peer-to-Peer Review with a medical professional in the same specialty as the treating physician.

The requested therapy was denied on the grounds that it is [cite reason for denial, e.g., considered experimental or not a covered benefit]. However, I believe an exception is medically necessary for this patient due to the following clinical reasons:

- **Clinical Diagnosis:** [Briefly describe the patient's condition and severity].
- **Previous Treatments:** [List failed therapies, medications, or contraindications to standard covered treatments].
- **Medical Necessity:** [Explain why this specific therapy is the only viable option to prevent clinical decline or improve functional status].

Clinical evidence and peer-reviewed literature supporting the use of [Name of Therapy] for this diagnosis are attached to this letter.

I request a Peer-to-Peer discussion to clarify the clinical nuances of this case. Please contact my office at [Phone Number] or [Email Address] to schedule a time for this review. We are available at the following times: [Provide 2-3 time slots].

Thank you for your immediate attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name and Title]
[NPI Number]