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

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Second-Level Appeal for Denial of Genetic Testing
Patient Name: [Patient Full Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]
Date of Denial: [Date of First Appeal Denial]

To the Appeals Review Committee,

I am writing to formally submit a second-level appeal regarding the denial of coverage for [Name of Genetic Test]. This test was ordered by my physician, [Physician Name], to address [Specific Medical Condition/Diagnosis].

I am disappointed by the previous decision to uphold the denial based on the claim that this test is [state reason given in denial, e.g., "experimental" or "not a covered benefit"]. I am requesting a formal review of this decision by an independent medical professional specializing in [Genetics/Oncology/Relevant Field].

This genetic test is medically necessary for the following reasons:

- [Explain how the test results will directly change the treatment plan].
- [Mention any family history or failed previous treatments].
- [Reference specific peer-reviewed clinical guidelines that support the test].

Attached to this letter, please find:

- A formal Letter of Medical Necessity from my treating physician.
- Relevant clinical notes and laboratory results.
- Peer-reviewed research and clinical trial data supporting the efficacy of this test.
- The initial denial letter and the first-level appeal response.

Under my policy and federal law, I am entitled to a thorough and fair review of this request. I look forward to a written response within the timeframe mandated by law.

Sincerely,

[Your Signature]
[Your Printed Name]