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

[Date]

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

RE: Financial Hardship Appeal for Non-Covered Service
Patient Name: [Patient Name]
Member ID: [ID Number]
Claim Number: [Claim Number, if applicable]
Provider Name: [Clinic/Doctor Name]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for [Name of Service/Procedure] provided at [Clinic Name] on [Date]. I am requesting a non-covered service exception based on documented financial hardship and medical necessity.

The medical service received was essential for my health because [Briefly explain why the service was medically necessary]. Although this service is listed as non-covered under my current plan, there are no comparable alternatives available within the network that meet my specific medical needs.

Currently, I am experiencing significant financial hardship due to [Briefly mention reason: e.g., loss of income, high medical debt, or low-income status]. Paying the full out-of-pocket cost of [Amount] would create an impossible financial burden and prevent me from receiving necessary ongoing care.

Enclosed, please find the following supporting documents:

- A letter of medical necessity from my physician.
- Proof of financial hardship (e.g., recent pay stubs, tax returns, or a summary of monthly expenses).
- [Any other relevant medical records].

I respectfully ask that you review this case and grant a one-time exception to cover this service, or reduce the patient responsibility to an in-network rate. Thank you for your time and consideration of this request.

Sincerely,

[Your Signature]
[Your Printed Name]