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

[Date]

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

RE: Continuity of Care Appeal / Transition of Care Request
Patient Name: [Patient Full Name]
Member ID Number: [ID Number]
Group Number: [Group Number]
Claim/Reference Number (if applicable): [Reference Number]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Treatment/Procedure/Prescription] and to request a Continuity of Care exception. This treatment is currently provided by [Doctor/Provider Name] at [Facility Name].

I am requesting this exception because I am currently in an active course of treatment for [Name of Medical Condition]. Changing providers or interrupting this specific treatment at this stage would pose a significant risk to my health and clinical outcome. My physician has determined that this treatment is medically necessary and that a transition to an alternative, covered treatment would be detrimental.

The following details support this request:

- **Diagnosis:** [Name of Condition]
- **Treatment Start Date:** [Date]
- **Current Status:** [Briefly describe clinical stability or stage of treatment]
- **Medical Risk:** [Briefly describe the risk if treatment is interrupted or changed]

Attached, please find a letter of medical necessity from my treating physician, [Doctor's Name], as well as relevant clinical documentation supporting the need for continued coverage of this specific treatment.

I look forward to your timely response regarding this appeal. Please contact me at [Phone Number] if you require further information.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from [Doctor's Name]
Relevant Medical Records
Copy of Original Denial Letter