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

[Date]

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

RE: Retroactive Authorization Appeal for Transition of Care
Patient Name: [Patient Full Name]
Member ID: [ID Number]
Claim/Reference Number: [Reference Number]
Date of Service: [Date]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for services provided on [Date] by [Provider Name]. The request for authorization was denied because it was not obtained prior to the service. I am requesting a retroactive authorization based on Transition of Care requirements.

At the time of service, I had recently [switched insurance plans / changed employers]. Because I was in the middle of an active course of treatment for [Condition Name], a gap in care would have posed a significant risk to my health. I was under the impression that Transition of Care protocols allowed for the continuation of services with my existing provider to ensure clinical stability.

The provider, [Provider Name], has been managing my care for [Duration], and it was medically necessary to maintain this relationship during the transition period to avoid [mention specific complication or risk].

Attached you will find supporting documentation, including my medical records and a statement from my provider regarding the necessity of uninterrupted care. I request that you review this claim under your Transition of Care policy and grant a retroactive authorization for the services rendered.

Thank you for your time and reconsideration of this matter. I look forward to your response within the standard regulatory timeframe.

Sincerely,

[Your Signature]

[Your Printed Name]