

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

[Date]

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

**RE: Second Level Appeal for Denial of Coverage**

**Patient Name:** [Patient Name]  
**Member ID:** [Member ID Number]  
**Group Number:** [Group Number]  
**Claim Number:** [Claim Number]  
**Date of Service:** [Date of Service]

Dear Appeals Committee Members,

I am writing to formally request a second-level appeal regarding the denial of the following procedures: [List Procedure Codes]. This request follows the initial denial and the subsequent first-level appeal decision dated [Date of First Appeal Denial].

The denial was based on the assertion that these procedures are "mutually exclusive" and cannot be billed together. I am contesting this decision based on the clinical necessity and the distinct nature of the services provided during the same session.

According to my healthcare provider, [Doctor's Name], these procedures were performed at separate anatomical sites and/or through separate incisions. They were both medically necessary to treat [Condition Name] and are not integral components of one another. [Insert specific clinical justification or mention of Modifier 59 if applicable].

Enclosed, please find the following supporting documentation:

- A formal letter of medical necessity from my treating physician.
- The operative report detailing the distinct nature of each procedure.
- Relevant clinical notes and diagnostic results.
- [List any other supporting documents].

I request that a different medical reviewer, who was not involved in the previous two decisions, re-evaluate this claim. Please review the attached evidence and reconsider the reimbursement for these services.

I look forward to your written response within [Number of Days allowed by plan, e.g., 30] days.  
Thank you for your time and attention to this matter.

Sincerely,

[Signature]

[Printed Name]