[Physician Name]
[Clinic/Hospital Name]
[Address]
[Phone Number]
[Date]

[Insurance Company Name]
[Appeals Department Address]

RE: Letter of Medical Necessity / Appeal for [Patient Name]
Patient Date of Birth: [DOB]
Policy Number: [Policy #]
Group Number: [Group #]
Claim/Reference Number: [Claim #]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally appeal the denial of coverage for [Specific Procedure, Medication, or Service]. It is my professional medical opinion that this treatment is medically necessary for the management of the patient's condition.

Clinical History:
The patient has been diagnosed with [Diagnosis/ICD-10 Code]. They have been under my care since [Date]. To date, the patient has attempted the following treatments which were unsuccessful or contraindicated: [List previous treatments/medications].

Medical Justification:
[Provide detailed medical reasoning. Explain why the requested service is the gold standard of care or why alternatives are inappropriate. Reference specific clinical trials or guidelines if applicable.]

Impact of Denial:
Without this treatment, [Patient Name] is at significant risk for [List risks: e.g., disease progression, hospitalization, permanent disability]. This intervention is essential to improve the patient's clinical outcome and quality of life.

I request that you overturn the previous denial and authorize coverage for this service. I have attached [List attachments: e.g., clinical notes, test results, peer-reviewed literature] to support this request.

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]