

[Insurance Company Name]
[Utilization Management Department]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

RE: NOTICE OF ADVERSE BENEFIT DETERMINATION

Patient Name: [Patient Name]
Member ID: [ID Number]
Claim/Reference Number: [Reference Number]
Provider: [Requesting Physician Name]

Dear [Patient Name],

We are writing to inform you that we have reviewed the request for prior authorization for the following service: **[Name of Procedure/Medication/Service]**.

At this time, we are unable to approve this request for the following reason(s):

[Insert specific reason for denial, e.g., Not medically necessary / Experimental / Lack of clinical documentation / Benefit exclusion].

Clinical Basis for Denial:

[Insert detailed explanation based on plan guidelines and medical necessity criteria used].

Your Right to Appeal:

You or your healthcare provider have the right to appeal this decision. If you disagree with our determination, you may submit a formal appeal within [Number of Days] days from the receipt of this letter.

To file an appeal, please send a written request and any additional supporting medical records to:

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

If this is an urgent medical situation, you may be eligible for an expedited (fast) appeal. Please contact our Member Services department at [Phone Number] for assistance.

Sincerely,

[Name of Reviewer/Medical Director]
[Title]
[Insurance Company Name]