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

[Date]

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

RE: Notice of Denial of Medical Coverage

Patient Name: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [Claim Number]
Date of Denial: [Date on Denial Letter]

To the Appeals Committee,

I am writing to formally appeal the denial of coverage for [Name of Procedure, Treatment, or Medication]. This request was denied on [Date] based on the assertion that the service is not medically necessary.

I believe this treatment is medically necessary for the following reasons:

- [Reason 1: Describe your medical condition and how it affects your daily life].
- [Reason 2: List previous treatments or medications that have failed].
- [Reason 3: Explain why this specific treatment is the standard of care for your diagnosis].

Attached to this letter, please find supporting documentation including a letter of medical necessity from my physician, [Physician Name], relevant medical records, and [List any peer-reviewed studies or clinical guidelines].

I request that you reconsider your decision and approve coverage for this essential treatment. I look forward to a written response within [Number] days as per the timeline outlined in my policy.

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures: [List attached documents]