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

[Date]

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

RE: Formal Appeal of Denial for [Medical Procedure/Medication Name]

Patient Name: [Patient Name]
Member ID Number: [Member ID]
Group Number: [Group Number]
Claim/Reference Number: [Denial Reference Number]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Name of Procedure, Medication, or Service] which was requested by my provider, [Doctor's Name]. I received the denial notification dated [Date of Denial Letter] stating that the request was denied because [Reason for denial stated in the letter, e.g., "not medically necessary"].

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

- [Reason 1: Describe your diagnosis and how this treatment addresses it]
- [Reason 2: Mention previous treatments that failed or why alternatives are not suitable]
- [Reason 3: Note any specific medical guidelines or research supporting the treatment]

Included with this letter is a supporting statement from [Doctor's Name], along with relevant medical records and [List any additional documents, e.g., clinical studies or lab results]. These documents demonstrate the clinical necessity of this treatment for my specific condition.

Please review this appeal and the attached documentation. I look forward to a timely response regarding the reversal of this denial. If you require any further information, please contact me at [Your Phone Number] or my physician's office at [Doctor's Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List of attached documents]