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

[Date]

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

RE: Letter of Appeal for Out-of-Network Services

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

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for services provided by [Provider/Facility Name] on [Date of Service]. My claim was denied because the provider is outside of the plan's network. I am requesting that this claim be processed at the in-network benefit level due to the following reasons:

[Select the applicable reason below and delete the others]:

- **Network Inadequacy:** There are no in-network providers within a reasonable distance who possess the necessary expertise to treat my specific condition, which is [Name of Condition].
- **Continuity of Care:** I have a long-standing relationship with this provider for a chronic condition, and switching providers at this stage would jeopardize my health and treatment progress.
- **Emergency Services:** These services were rendered during a medical emergency where I did not have the option to choose an in-network facility.
- **Referral/Prior Authorization:** I was referred to this specialist by my primary care physician, and I was under the impression the services were authorized.

Attached you will find supporting documentation, including [list documents, e.g., medical records, a letter of medical necessity from your doctor, or maps showing lack of local providers].

I look forward to your timely response regarding this matter. Please notify me of your decision within [number of days required by law/plan] days.

Sincerely,

[Your Signature]

[Your Printed Name]