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

[Date]

[Name of Recipient/Appeals Department]
[Name of Insurance Company/Organization]
[Address]
[City, State, Zip Code]

RE: Appeal for Maximum Benefit Exceeded
Patient Name: [Patient Full Name]
Member ID Number: [Policy ID Number]
Claim Number: [Claim Number associated with denial]
Date of Service: [Date]

Dear [Name of Contact Person or Appeals Committee],

I am writing to formally appeal the denial of coverage for [Specific Treatment, Medication, or Service] received on [Date]. According to the Explanation of Benefits (EOB) dated [Date], the claim was denied because the maximum benefit for this service has been reached.

I am requesting a formal review and an extension of benefits based on medical necessity. My healthcare provider, [Doctor's Name], has determined that continued [Treatment/Service] is essential for my recovery and long-term health. [Briefly explain the medical reason why more treatment is needed beyond the cap].

Attached to this letter, please find the following supporting documentation:

- A letter of medical necessity from my physician.
- Relevant clinical notes and progress reports.
- [Any other supporting evidence, such as test results or specialist recommendations].

Without continued coverage for these services, I am at risk for [List potential health risks or setbacks]. I request that you grant an exception to the benefit limit to ensure I receive the necessary care prescribed by my medical team.

Thank you for your time and for reconsidering this claim. I look forward to your written response within [Number] days as per the policy guidelines.

Sincerely,

[Your Signature]

[Your Printed Name]