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

[Date]

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

RE: Appeal of Coverage Denial for [Patient Name]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

Dear Appeals Committee,

I am writing to formally appeal your decision to deny coverage for [name of procedure or treatment] on the grounds that it is related to a pre-existing condition.

I believe this denial is in error for the following reasons:

- [Reason 1: e.g., The condition was not previously diagnosed or treated prior to the enrollment date.]
- [Reason 2: e.g., The current treatment is for a new, unrelated medical issue.]
- [Reason 3: e.g., Documentation from my physician is attached confirming this is not a pre-existing condition.]

Attached to this letter, please find supporting documentation, including medical records from [Doctor's Name] and a letter of medical necessity. These documents clarify that the condition for which I am seeking coverage does not meet the criteria for a pre-existing condition exclusion under the terms of my policy and applicable laws.

I request that you review this claim again and provide a written response regarding your decision within [number of days, e.g., 30] days. If the denial is upheld, please provide a detailed explanation of the specific policy language and medical evidence used to reach that conclusion.

Thank you for your time and immediate attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
[List of medical records attached]
[Letter from physician]
[Copy of original denial letter]