

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

[Date]

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

RE: Notice of Appeal for Denial of Medical Services

Patient Name: [Patient Name]
Policy Member ID: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]
Service/Medication Requested: [Name of Service or Medication]

To Whom It May Concern,

I am writing to formally appeal your decision to deny coverage for [Name of Service/Medication] requested by my physician, [Physician Name]. This request was denied on [Date of Denial Letter] for the following reason: [Reason for denial stated in the letter].

I believe this treatment is medically necessary for my condition because [briefly describe how the treatment helps or why previous treatments failed]. Attached to this letter, please find supporting documentation from my healthcare provider, including medical records and a letter of medical necessity.

I am requesting that you reconsider this denial and approve the authorization for the requested service immediately. Please provide a written response to this appeal within the timeframe required by my policy.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]

[Printed Name]

Enclosures:
- Copy of Denial Letter

- Letter of Medical Necessity from [Physician Name]
- Relevant Medical Records