

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

[Insurance Carrier Name]  
[Claims Adjuster Name]  
[Address]  
[City, State, Zip Code]

**RE: Appeal of Prescription Authorization Denial**

Claim Number: [Your Claim Number]  
Date of Injury: [Date of Injury]  
Medication Requested: [Name of Prescription]

To Whom It May Concern,

I am writing to formally appeal the denial of authorization for the prescription medication [Name of Medication], which was prescribed by my treating physician, [Doctor's Name], on [Date of Prescription]. I received notice of this denial on [Date of Denial Notice].

This medication is necessary for the treatment of my work-related injury. According to my physician, this specific prescription is required because:

- [Reason 1: e.g., Previous medications have failed]
- [Reason 2: e.g., It is the standard of care for this specific diagnosis]
- [Reason 3: e.g., Necessary to allow participation in physical therapy]

Attached to this letter, please find a supporting statement from my doctor and relevant medical records highlighting the medical necessity of this treatment. Without this medication, my recovery is being delayed and my ability to return to work is hindered.

I request that you reconsider this denial and provide authorization for this prescription immediately. Please provide a written response regarding your decision within [Number of Days] days.

Sincerely,

[Your Signature]  
[Your Printed Name]

Enclosures: [Doctor's Letter, Medical Records, Denial Notice Copy]