[Date]

Claimant Name: [Employee Full Name]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]
Employer: [Employer Name]

Dear [Employee Name],

This letter is to inform you of the decision regarding your request for medical treatment or services related to the workers' compensation claim referenced above.

Coverage Decision:

After reviewing your file and the medical documentation provided, we have **approved** the following treatment(s):

- [List Approved Treatment/Service 1]
- [List Approved Treatment/Service 2]

However, we are **denying** coverage for the following requested treatment(s) or services at this time:

- [List Denied Treatment/Service 1]
- [List Denied Treatment/Service 2]

Reason for Partial Denial:

The denial of the specified treatment is based on the following reason(s):
[Insert Reason: e.g., Treatment not medically necessary, treatment unrelated to the work injury, or lack of supporting clinical documentation.]

Your Right to Appeal:

If you disagree with this partial denial, you have the right to request a review of this decision. To appeal, you must submit a written request to the address below within [Number] days of receiving this letter. Please include any additional medical records or evidence you wish to be considered.

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

If you have questions regarding this notice, please contact your Claims Adjuster, [Adjuster Name], at [Phone Number].

Sincerely,

[Signature]
[Printed Name]
[Title/Company Name]

cc: [Treating Physician Name]