[Date]

[Member Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

RE: Final Internal Appeal Determination

Member ID: [ID Number]
Claim/Reference Number: [Number]
Service Requested: [Description of Service/Treatment]

Dear [Member Name],

This letter is to inform you that we have completed our formal review of your appeal regarding the denial of coverage for [Service/Treatment]. We have upheld the original decision to deny coverage.

Reason for Denial:
[Insert specific reason, e.g., the service is not medically necessary, is considered experimental, or is a contract exclusion].

Clinical Basis:
Our medical director reviewed [List documents reviewed, e.g., clinical notes, peer-reviewed literature]. Based on [Plan Criteria/Clinical Guidelines], it was determined that [Detailed explanation of why criteria were not met].

Exhaustion of Internal Appeals:
This is the final level of our internal appeal process. You have now exhausted all internal mandatory appeal requirements.

External Review Rights:
You may have the right to request an independent External Review by a third-party organization. To request this, you must submit a written application to [Department/Address] within [Number] days of receiving this letter.

Additional Information:
You are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim. If you have questions, please contact our Appeals Department at [Phone Number].

Sincerely,

[Name/Signature]
[Title]
[Health Plan Name]