[Date]

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

RE: Final Appeal Determination

Reference Number: [Claim or Appeal Number]
Date of Service: [Date]
Provider: [Provider Name]

Dear [Member Name],

We are writing to notify you that we have completed our review of your appeal regarding the claim/service mentioned above. We have overturned our original decision and have granted **Full Approval**.

Decision Summary:
Based on the additional clinical documentation provided and a secondary review by our medical team, it has been determined that the requested service/claim meets the criteria for medical necessity under your benefit plan.

Next Steps:
The claim will be reprocessed for payment in accordance with your plan benefits, including any applicable deductibles, co-pays, or co-insurance. You should receive a new Explanation of Benefits (EOB) within [Number] business days reflecting this update.

If you have already paid the provider for these services, please contact their billing office regarding a refund based on this approval.

If you have any questions regarding this final determination, please contact our Appeals Department at [Phone Number], Monday through Friday, from [Hours].

Sincerely,

[Name/Signature]
[Title]
[Department Name]
[Organization Name]