DATE: [Insert Date]

TO:
[Claimant Name]
[Claimant Address]
[City, State, Zip Code]

RE: FINAL DETERMINATION OF APPEAL
Claim Number: [Insert Claim Number]
Date of Injury: [Insert Date of Injury]
Employer: [Insert Employer Name]

Dear [Claimant Name],

This letter serves as the formal Final Determination regarding your appeal dated [Date of Appeal Filing] concerning the workers' compensation claim referenced above.

The Appeals Committee has completed a comprehensive review of your file, including the original claim decision, the evidence submitted during the appeal process, and any additional medical documentation provided. After careful consideration, the following decision has been reached:

DECISION:
[Choose one: UPHOLD ORIGINAL DENIAL / REVERSE ORIGINAL DENIAL / MODIFY ORIGINAL DECISION]

REASONING:
[Insert a detailed explanation of the findings and the specific reasons for the final determination.]

BENEFIT STATUS:
[Insert details regarding payment of medical bills, disability benefits, or notification that no further benefits will be paid.]

This decision constitutes the final administrative action by [Name of Insurance Carrier/Agency].

If you disagree with this final determination, you may have the right to seek further judicial review through the [State/Regional] Workers' Compensation Commission or the appropriate court of law. Please note that there are strict statutory deadlines (statutes of limitations) for filing such an action.

Sincerely,

[Signature]
[Name of Authorized Representative]
[Title]
[Organization Name]

CC: [Employer Name], [Legal Counsel, if applicable]