[Date]

[Appellant Name]
[Address Line 1]
[City, State, Zip Code]

RE: Final Determination of Appealed Claim

Claim Number: [Claim Number]
Appeal Reference: [Appeal Reference Number]
Date of Original Decision: [Original Decision Date]

Dear [Appellant Name],

We have completed a formal review of your appeal regarding the claim referenced above. After a thorough evaluation of all available information, including the additional documentation provided during the appeals process, we have reached a final determination.

Decision:

The original decision dated [Original Decision Date] is **upheld**. Our initial determination remains unchanged.

Reasoning for Determination:

The appeal was denied based on the following factors:

- [Insert Reason 1: E.g., The services provided do not meet the criteria for coverage under the current policy.]
- [Insert Reason 2: E.g., The documentation submitted did not establish medical necessity.]
- [Insert Reason 3: E.g., The claim was submitted outside of the required filing timeframe.]

Finality of Decision:

This letter serves as the final administrative determination regarding this specific claim. You have now exhausted the internal appeals process provided by [Company Name].

Next Steps:

If you disagree with this final internal decision, you may have the right to pursue further action, such as:

- Requesting an External Review by an independent third party.
- Contacting your State Department of Insurance or relevant regulatory body.
- Bringing a civil action under Section 502(a) of ERISA (if applicable).

Please refer to your [Plan Document/Policy Handbook] for specific timelines and instructions regarding external reviews.

Sincerely,

[Name of Reviewer/Department]
[Company Name]
[Contact Phone Number]