[Date]

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

RE: Final Determination of External Review

Case Number: [Case ID Number]
Claim Number: [Claim Number]
Patient Name: [Patient Name]

Dear [Appellant Name],

This letter serves as the official final determination regarding the external review of the denied claim mentioned above. The External Review Board has completed its independent evaluation of all documentation, clinical records, and arguments provided by both the claimant and the insurance provider.

Decision:

[UPHELD / OVERTURNED / PARTIALLY OVERTURNED]

Summary of Findings:

[Insert a concise summary of the clinical or contractual reasoning used to reach the decision. Reference specific plan language or medical necessity guidelines used during the review.]

Impact of Decision:

[If Upheld: The original denial stands, and no further benefits will be paid for this specific claim.]

[If Overturned: The insurance provider is directed to process the claim for payment in accordance with the terms of the health plan.]

Finality of Decision:

Pursuant to [Applicable Law/Regulation], this decision is binding upon the plan and the claimant. This concludes the administrative appeals process. You may have additional rights to pursue legal action under Section 502(a) of ERISA if your plan is governed by federal law.

Should you have questions regarding this notice, please contact the External Review Coordinator at [Phone Number].

Sincerely,

[Signature]
[Name of Reviewer/Chairperson]
[External Review Organization Name]