[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Claims Adjuster Name]
[Insurance Company Name]
[Address]
[City, State, Zip Code]

RE: Request for Reconsideration of Denied Claim
Claim Number: [Your Claim Number]
Date of Injury: [Date]
Employer: [Employer Name]

Dear [Claims Adjuster Name],

I am writing this letter in good faith to formally request a reconsideration of the denial of my workers' compensation claim, as stated in the notice dated [Date of Denial Letter].

I believe that the denial may have been based on incomplete information or a misunderstanding of the circumstances surrounding my injury. I would like to provide the following additional information and clarification for your review:

- [Reason 1: e.g., Clarification on how the injury occurred during work duties]
- [Reason 2: e.g., Reference to attached additional medical records or physician statements]
- [Reason 3: e.g., Witness statements or workplace reports not previously submitted]

I am committed to resolving this matter efficiently and amicably. I have attached the following supporting documents to assist in your re-evaluation:

[List attached documents, e.g., Medical reports, MRI results, Witness contact info]

Please review this additional information and notify me of your decision regarding the reconsideration of my claim. I look forward to your response within [Number of days, e.g., 14] business days.

Thank you for your time and professional consideration of this request.

Sincerely,

[Your Signature]

[Your Printed Name]