

[Your Name]
[Address]
[City, State, ZIP]
[Phone Number]
[Email]
[Date]

Appeals Committee

[Insurance Company Name]

[Address]

[City, State, ZIP]

Re: Prior Authorization Appeal –

Claim #[Claim Number]

Patient / Member Information

Member Name: [Your Full Name]

Member ID / Policy Number: [Policy Number]

Date of Birth (DOB): [MM/DD/YYYY]

CPT / HCPCS Code(s): [List codes]

Place of Service (POS): [Facility / Office / Ambulatory, etc.]

Date of Service: [MM/DD/YYYY]

Date of Denial: [MM/DD/YYYY]

Reference / Denial Number: [Reference from denial letter]

Treatment / Service Denied: [Specific Treatment / Procedure]

Appeal Letter Body

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for **[treatment/procedure]** received on **[date of service]**, referenced in your denial letter dated [date of denial letter], which stated that the treatment was denied because **[reason from denial letter]**. After reviewing my policy and consulting with my physician, I believe this denial was made in error. I respectfully request a full review and approval of this treatment.

[ANNOTATION: Opening clearly identifies the purpose and references specific details about the denial]

I have been diagnosed with **[condition]** since **[date of diagnosis]**. My medical history includes **[brief relevant medical history that establishes need for treatment]**. Before recommending **[denied treatment]**, my physician tried the following treatments: **[list previous treatments]**, all of which were unsuccessful in managing my condition because **[explain why previous treatments failed]**.

[ANNOTATION: Establishes medical history and progression of treatment, showing that denied treatment wasn't the first option]

Dr. [Physician's name], a board-certified [specialty] with [x] years of experience treating [condition], has determined that [denied treatment] is medically necessary for my condition. In their professional medical opinion (attached as Exhibit A), this treatment is not experimental but rather the standard of care for patients with my specific condition and medical history.

[ANNOTATION: Introduces expert medical opinion and establishes physician's credentials]

The denial letter classifies this treatment as [reason for denial, e.g., "experimental" or "not medically necessary"]. However, this classification contradicts current medical literature and practice guidelines. The [Name of Medical Association] guidelines updated in [year], state that [quote from guidelines supporting treatment]. Additionally, a peer-reviewed study published in the [Journal Name] (attached as Exhibit B) demonstrated that this treatment improves outcomes for patients with my condition by [cite specific statistics or findings].

[ANNOTATION: Directly challenges the denial reason with evidence from medical literature]

Furthermore, my insurance policy states under section [section number], page [page number]: "[quote from your policy that supports coverage]". This indicates that the denied treatment should be covered according to the terms of my policy.

[ANNOTATION: References specific policy language that supports coverage]

This treatment is urgently needed because [explain impact of delay on your health]. My physician has indicated that postponing this treatment could result in [describe potential negative health outcomes].

[ANNOTATION: Establishes urgency and potential harm from denial]

Supporting Documents

I have attached the following documents to support my appeal:

1. Letter from Dr. [Name] explaining medical necessity (Exhibit A)
2. Relevant medical records documenting my condition (Exhibit B)
3. Published medical studies supporting this treatment (Exhibit C)
4. Treatment guidelines from [Medical Association] (Exhibit D)

[ANNOTATION: Clearly lists supporting documentation]

I request that you review this appeal promptly and reverse the denial decision. If additional information is needed to process this appeal, please contact me at [phone] or [email].

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Doctor's Name]

[Your State's Insurance Commissioner]

[Your Employer's HR Department, if applicable]