Your Name

Your Address

**[~Current Date~]**

Attn: Director of Claims

**[~Insurance Company Name~]**

**[~Insurance Company’s Appeal Address]**

 Re: Patient**: [~Patient Name~]**

 Policy: **[~Insurance Policy Number~]**

 ID Number: **[~Unique Member ID Number~]**

 Insured: **[~Responsible Party Name~]**

 Claim Number: **[~Carrier Claim Number~]**

 Treatment Date: **[~Date(s) of Service~]**

 Amount: **[~Provider’s Total Charge~]**

Dear Director of Claims,

Please accept this letter as my formal appeal to **[~insurance company name~]**’s decision to deny coverage for [~**state the name of the specific procedure denied**~]. It is my understanding, based on your letter of denial dated **[~date of denial letter or explanation of benefits~],** that this procedure has been denied due to [~ **Quote the specific reason for the denial stated in denial letter**~].

**[~Explain event from date of service here, with supporting information as to why the service was medically necessary and why it should be a covered service. Be specific as possible.~]**

Based on this information, I am asking that you reconsider your adverse decision and allow coverage for the procedure outlined in this letter. Please contact me at xxx-xxx-xxxx if you need any additional information.

Sincerely,

**[~Your Name~]**

Suggested enclosures:

Ask your doctor for a letter of medical necessity

Obtain medical records relating to this date of service and illness

Obtain medical articles/journals to further support medical necessity