

[Date]

[Name of insurance company]

[Address]

[City, State, ZIP code]

Re: [Patient's name]

[Policy number]

[Date of birth]

To whom it may concern:

I am writing to request that you reconsider your denial of coverage for [PRODUCT NAME] for [insert patient's name]. I understand the reasons for the denial are [include the reasons from the letter you received from the insurance company].

Listed below are the reasons why [my/his/her] doctor prescribed [PRODUCT NAME]:

[Insert information the doctor gave you about the diagnosis; medical history, including previous therapies and results; the treatment plan; and other supporting information.]

I have also enclosed [insert descriptions of supporting documents the doctor gave you] outlining why [my/his/her] doctor believes [I/he/she] should be treated with [PRODUCT NAME].

Please approve this request so [I/he/she] can start treatment with [PRODUCT NAME] as prescribed by [my/his/her] doctor.

[My/His/Her] doctor may be contacted at [insert the doctor's phone number] for any additional information you may require regarding this request. You can also contact me at [insert your phone number]. I look forward to your timely approval of this appeal.

Sincerely,

[Sign and print your name here]

Attachments: [Enclose denial letter and supporting documentation]