[Physician Practice letterhead]
[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] [dose and frequency] that I prescribed for my patient, [patient's full name]. Your reason for denial was [insert health insurance plan's reason for denying coverage].

I still believe [PRODUCT NAME] is appropriate for my patient. Listed below are my patient's diagnosis, medical history, treatment plan, and other supporting information, which confirm the medical necessity and appropriateness of [PRODUCT NAME].

Patient's diagnosis, medical history, treatment plan, and other supporting information

[Insert information regarding the patient's diagnosis; medical history, including previous therapies and results; treatment plan; and other supporting information.]

I hope you will agree [PRODUCT NAME] is appropriate and medically necessary for [patient's name] and provide coverage for this treatment. Enclosed in support of this appeal are [insert description of supporting documents].

Thank you in advance for your consideration. Please contact me at [office phone number] for any additional information you may require regarding this request. I look forward to your timely approval of this appeal.

Sincerely,
[Sign and print your name here]

Attachments: [Enclose denial letter and supporting documentation]