Sample Letter of Appeal

Date of request: [Date]

[Request for Expedited Review]

ATTN: Prior Authorizations/Appeals

[Contact name]
[Health plan name]
[Health plan address]
[City, State ZIP Code]
[Fax number]

RE: Appeal for Denial of [Product name]

[Insured Patient First Name Patient Last Name]

Date of birth: [Month Day, Year]

[Policy #][Group #]

Diagnosis: [ICD-10-CM Code][Diagnosis]

[Claim or Reference # (if known)]

Submission date: [Submission date] Denial date: [Denial date]

To whom it may concern:

My name is [Provider First Name Provider Last Name, medical specialty (National Provider Identifier number)], and I am writing on behalf of [Patient First Name, Patient Last Name] to appeal the denial of coverage for [Product name]. [Patient name] has been in my care since [date] for the [FDA-approved indication].

In a letter dated [date of denial letter], coverage for [Product name] was denied due to [reason(s) for denial stated in denial letter]. I have reviewed your letter and, based on my medical expertise, believe that [Product name] is the appropriate treatment for [patient name] because [rationale for prescribing [Product name]].

Based upon my clinical judgment, I request that you consider approving [Product name] for my patient. I have enclosed additional documentation to further support medical necessity of [Product name] for [patient name]. My office can be contacted at [phone number] or [email address] if additional information is required to overturn this decision.

Thank you in advance for your timely attention to this matter.

Sincerely,

[Physician name, medical specialty, National Provider Identifier number]

[Physician address]

Phone number: [Physician phone number] Fax number: [Physician fax number]

Enclosures [for consideration]:

[Relevant patient medical records]

[Letter of Medical Necessity]

[Prescribing Information]

[FDA Approval Letter(s)]

[Peer-reviewed literature (eg, treatment guidelines)]

[National Headache Foundation Position Statement]