SAMPLE LETTER TEMPLATE OF DENIAL APPEAL
(FOR PROVIDERS)

[Date]
[Contact Name]
[Insurance Company]
[Insurance Company Address]
[City, State ZIP Code]
[Fax Number]

ATTN: Prior Authorizations/Appeals

Re: Coverage of [Product Name/generic name/dosage form]
[Patient First Name] [Patient Last Name]
[Policy Number]
[Group Number]
[Patient Date of Birth]
[ICD-10-CM Code] [Diagnosis]
[Claim or Reference Number]
[Submission Date]
[Denial Date]

To whom it may concern:

I am writing to request a review of a denial for coverage of [Service or Goods Rendered] for [Patient Name]. Your company has denied this claim for the following reasons:

[Write out reasons here.]

[Patient Name]'s medical history and course of treatment are as follows:

[Describe the patient's history, including diagnostic test results, previous and current treatment regimens, and their outcomes.]

Based on the information provided above, the use of [Service or Goods Rendered] is medically appropriate and necessary for [Patient Name]. I have enclosed a copy of the Full Prescribing Information for [Service or Goods Rendered].

I respectfully request that you review the additional documentation provided and consider overturning your coverage decision regarding [Service or Goods Rendered] for [Patient Name]. Thank you for your prompt assistance with this matter. If I can provide any additional information, please contact me. I look forward to your reconsideration.

Regards,
[Physician Name]
[NPI Number]
[Phone Number]
[Fax Number]

Suggested enclosures:

- Original prior authorization form
- Denial letter/EOB
- Full Prescribing Information
- Medical literature regarding the use of [Service or Goods Rendered] for [ICD-10 Code] [Diagnosis]
- Relevant clinical documentation (eg, history and physical, progress notes describing treatment history and outcomes)
- Other relevant supporting documents