SAMPLE LETTER OF APPEAL

[Name]
[Insurance Company/Payer Name]
[Address]
[City, State, Zip]
[Date]

RE: Member Name: [Member Name]
Member Number: [Member Number]
Group Number: [Group Number]

EXPEDITED REQUEST: Authorization for treatment with [Medication]

Dear Medical or Pharmacy Director:

I am writing to request a review of a denial for [Patient Name] for [Medication] treatment. Your company has denied this claim for the following reason(s):

[List reason(s)]

My request is supported by the following:

Summary of Patient History

[You may consider including (NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.)

- Patient's diagnosis, date of diagnosis, and history
- Previous therapies and procedures the patient has undergone for management of patient's condition
- Patient's response to these therapies
- Summary of your professional opinion of the patient's likely prognosis without treatment]

Rationale for Treatment

Considering the patient's history, condition, and the full Prescribing Information supporting use of [Medication], I believe treatment at this time is [provide clinical justification for treatment].

I respectfully request that you review the additional documentation provided and consider overturning your coverage decision for [Medication]. I look forward to your reconsideration. Contact my office at [Phone Number] if I can provide you with any additional information to ensure prompt approval of this course of treatment.

Sincerely,

[Doctor Name]

[Participating Provider Number]

Enclosures

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