[Date]

ATTN: **[Name of Contact or Medical Review/Appeals]**
[Name of Health Insurance Company]
[Street Address]
[City, State, ZIP code]

Insured: **[Patient First and Last Name]**
Policy Number: **[Policy Number]**
Group Number: **[Group Number]**
RE: **[Drug Name]** Claim Denial

Dear **[Name of Contact]**,

This is a formal letter of appeal for reconsideration of coverage on behalf of my patient, **[Patient Name],** for **[Drug Name]** which is indicated for the treatment of **[Disease]**.
[Insurance Company] has stated that **[Drug Name]** is not covered because **[Denial Reason].**
I am requesting prompt reevaluation of the claim denial for **[Drug Name]** provided to my patient on **[Date(s) of Service].**

Clinical History
Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition. You may want to include the following information, as applicable.
• Brief description of patient's age, diagnosis, prior treatments, and response to treatments
• Presentation, comorbidities, and other factors that impact the treatment decision

Rationale for [Drug Name]
The FDA has approved **[Drug Name]** for the treatment of **[Indication]** ***[Insert supporting language from FDA approved Prescribing Information].***
According to the explanation of benefits (EOB), **[Name of insurer/Medicare contractor]** denied this claim because **[insert reason, as stated on EOB, for denial]**. This letter serves to request a formal appeal of claim **[Claim Number]** for **[Patient Name]**, with policy number [**Policy Number**].

[Explain why [Drug Name] was selected for the patient]

Sincerely,
[Treatment Provider's Signature]
[Treatment Provider's Name Printed]
[Treatment Provider's Phone Number]

Enclosures:
(Suggested)
[Explanation of Benefits/Denial Letter]
[Copy(ies) of original claim form]
[Prescribing information for [Drug Name]]
[Clinical notes]
[Medication records including dates of prior therapy]
[Other supporting documentation]