

This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when responding to a request from a patient's insurance company for an appeal of coverage. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional.

[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]**