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]