[Date]

[Contact Name]
[Insurance Company]
[Insurance Address]
[Insurance City, State Zip]

Re: [Patient First Name] [Last Name]
[Policy Number]
[Group Number]
[Diagnosis]

Dear [Name or Contact]:

This letter serves as a formal appeal for reconsideration of coverage and adequate payment for [PRODUCT] [(generic)], which was originally denied to [Patient First Name] [Patient Last Name], on [Date of Service]. [Patient First Name] [Patient Last Name], has been under treatment for [Diagnosis] since [Date of Onset]. [Insurance Company Name] has stated that [PRODUCT] is not covered because [Denial Reason].

Treatment Information

[PRODUCT] [(generic name)], is FDA-approved and is indicated for the treatment of patients who have been diagnosed with [FDA approved indication]. [Continue with additional [PRODUCT] details…]

Patient History and Diagnosis

[Patient First Name] is a [Age]-year-old [male/female] who has been under treatment for [Diagnosis] since [Date]. During this time, [he/she] has been treated with other therapies including [discuss previous therapies and patient's response to therapy]. [Continue with patient history and clinical support for medical necessity...]

It is crucial that [Insurance Company Name] provide adequate coverage for [PRODUCT] for this patient with the intent of providing the best medical treatment available for [Diagnosis].

On behalf of [Patient First Name] [Patient Last Name], we urge your reconsideration of coverage and adequate payment for [PRODUCT]. Please call me at [Primary Treating Site Phone Number] if I can be of further assistance or you require additional information. If you have any questions about [PRODUCT], please call [Program Name] at [Phone Number], Monday through Friday, [Hours of Operation] [Time Zone].

Sincerely,

[Treating Provider First Name] [Treating Provider Last Name], [Treating Provider Title]