

(Date)

(Name)

(Insurance Company Name)

(Address)

(City, State ZIP)

Re: (Patient's Name)

(Type of Coverage)

(Group number/Policy number)

Dear (Name of contact person at insurance company),

Please accept this letter as my appeal to (insurance company name) decision to deny coverage for (state the name of the specific procedure denied). It is my understanding based on your letter of denial dated (insert date) that this procedure has been denied because:

(Quote the specific reason for the denial stated in denial letter)

I have been a member of your (state name of PPO, HMO, etc.) since (date). During that time I have participated within the network of physicians listed by the plan. However, my primary care physician, Dr. (name) believes that the best care for me at this time would be (state procedure name). At this time there is not a physician within the network who has extensive knowledge of this procedure. Dr. (name of primary care physician), a plan provider, has recommended that I have the procedure done outside the network by Dr. (name of specialist) at (name of treating facility).

I have enclosed a letter from Dr. (name of primary care physician) explaining why he recommends (name of procedure). I have also enclosed a letter from Dr. (name of specialist) explaining the procedure in detail, his qualifications and experience, and several articles that discuss the procedure.

Based on this information, I am asking that you reconsider your previous decision and allow me to go out of network to Dr. (name) for (name of specific procedure). The procedure is scheduled to begin on (date). Should you require additional information, please do not hesitate to contact me at (phone number). I look forward to hearing from you in the near future.

Sincerely,

(Your name)