Sample Letter of Appeal

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 for coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional.

[Date]
[Insurance Company Contact]
[Insurance Company Name]
[Insurance Company Address]
[Insurance Company City, State, ZIP]

Re:
Patient: [Patient's First and Last Name]
Subscriber ID #: [Insurance Subscriber ID]
Subscriber Group #: [Insurance Group ID]
Date of Birth: [Patient's Date of Birth]

Dear [Insurance Company Contact]:

Please accept this letter as [Patient's First and Last Name]'s appeal to [Insurance Company Name]'s decision to deny coverage for [medication name] for oral inhalation use.

I have read and acknowledge your policy for the responsible management of drugs in this category. It is my understanding, based on your letter of denial dated [date of denial letter], that coverage for treatment with [medication name] was denied because [insert specific reason as stated in the denial letter].

[Patient's First and Last Name] requests that you reconsider your denial of coverage of [medication name].

As you know, [Patient's First and Last Name] was diagnosed with [diagnosis] on [insert date of diagnosis], and I believe that [Patient's First and Last Name] requires this medication for the reasons stated in the attached letter of medical necessity and accompanying documentation.

After reviewing the attached information, I hope that you will agree that [medication name] is medically necessary for this patient. Should you require additional information, please do not hesitate to contact my office by calling [Practice Phone Number]. I look forward to receiving your timely response and approval of [medication name] for [Patient's First and Last Name].

Sincerely,

[Physician's Signature]

[Physician's Name]
[Provider Identification Number]
[Name of Practice]
[Phone Number]

[Patient's Signature]

[Patient's Name]

Enclosures: (attach as appropriate)

- Letter of Medical Necessity
- Prescribing Information (PI)
- Patient clinical/diagnostic notes and relevant lab reports