Instructions for Completing the Sample Letter of Appeals

Sample Letter of Appeals

This sample letter includes examples of information that may be required when responding to a health plan's denial of coverage. This guide is for informational purposes only and does not constitute medical, legal, or reimbursement advice and it makes no guarantee of coverage or reimbursement for any product. Requirements may vary by plan and individual health insurance policies are updated frequently. Plans may require the use of a specific template or form when submitting an appeal. It is the responsibility of the healthcare provider and/or office staff to ensure all necessary information is provided and accurate.

[Institution Letterhead]
[Date]

ATTN:	RE:
[Health Plan]	[Patient name]
[Address]	[Date of birth]
[City, State, ZIP Code]	Policy number: [Policy number]
[Phone]	Group number: [Group number]
[Fax]	Medicare Beneficiary Identifier (if applicable): [MBI]
	Medicaid number (if applicable): [Medicaid number]
	Claim/Case number: [Claim/Case number]

Subject: Request for reconsideration of denied coverage of [Brand name] for [Patient name]

Dear [Medical Director/Pharmacy Director/Payer contact],

I am writing to request that you reconsider the denial of [Brand name] to treat [diagnosis] for [Patient Name]. The denial letter dated [month/day/year] from [Health Plan] states that [Brand name] was not covered for my patient because [reason(s) listed in the denial letter].

I have reviewed the letter and, based on my medical expertise, I request that you reconsider this decision. [Brand name] was approved by the US Food and Drug administration for [indication] on [month/day/year]. [Please see the [Brand name] Prescribing Information and FDA approval letter attached.]

[Patient name] has been under my care since [month/day/year] and was diagnosed with [diagnosis] on [month/day/year]. Please see [Patient name]'s medical history below, which helped inform my treatment decision.

Symptoms:
[Include a brief description of patient's symptoms and recent test results/diagnostics that help support the treatment decision]

[Summarize patient's relevant medication history, including inadequate response to current or previous treatments. If applicable, include rationale for why other medications on formulary are not appropriate for your patient]

Current treatments for [diagnosis]:

Treatment	Patient response	Start date

Previous treatments tried and failed:

Treatment	Patient response	Date of discontinuation	Reason for discontinuation

Please find enclosed [list of documents provided], which help support my treatment decision.

Based on the enclosed documents and the information above, I believe [Brand name] is medically appropriate for my patient.

Thank you for your time and for reconsidering the denial of [Brand name] for [Patient name]. If you have any questions about the request, or need any additional information, please contact me at [phone number and email]. I look forward to your response.

Sincerely,
[Physician Name, credentials
Title
Signature
Phone number
Email address]

Enclosures: [Suggested enclosures include

- [Brand name] Prescribing Information
- FDA approval letter for [Brand name]
- Relevant medical records and test results
- Relevant publications, including clinical trials and treatment guidelines]

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Date:

ATTN:

RE:

Policy number:

Group number:

Medicare Beneficiary Identifier (if applicable):

Medicaid number (if applicable):

Claims/Case number:

Subject: Request for reconsideration of denied coverage of for

Dear ,

I am writing to request that you reconsider the denial of to treat for . The denial letter dated from states that was not covered for my patient because .

I have reviewed the letter and, based on my medical expertise, I request that you reconsider this decision. was approved by the US Food and Drug administration for on .

[ ] has been under my care since [ ] and was diagnosed with [ ] on [ ].

Please see [ ] 's medical history below, which helped inform my treatment decision.

Symptoms:

Current treatments for [ ] :

Treatment	Patient response	Start date

Previous treatments tried and failed:

Treatment	Patient response	Date of discontinuation	Reason for discontinuation

Please find enclosed [ ], which help support my treatment decision.

Based on the enclosed documents and the information above, I believe [ ] is medically appropriate for my patient.

Thank you for your time and for reconsidering the denial of [ ] for [ ]. If you have any questions about the request, or need any additional information, please contact me at [ ]. I look forward to your response.

Sincerely,

[ ]
[ ]
[ ]
[ ]
[ ]

Enclosures:

[ ]

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