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]

RE:
[Patient name]
[Date of birth]
Policy number: [Policy number]
Group number: [Group number]
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 nu	mber:]		
		Group n	umber:]		
		Medicare	e Beneficiary	Identifie	r (if app	licable):		
			l number (if a ase number:		e):			
Subje	ct: Request for recon	sideratio	n of denied c	overage	of		fo	or
Dear						,		
l am w	vriting to request tha		onsider the d	lenial of				to treat
		for				. The denial	ן	
from	it because		states that				was not co	vered for my
putien] ·
I have	reviewed the letter	and, base	d on my med	lical expe	ertise, I	request that	you reconsic	ler this
decisio	on.		was approv	ed by th	e US Fo	od and Drug	administrati	on for
		on						
1								

	has	been unde	r my c	are since				and was diagnosed with
	on].				
Please see			s me	dical histo	ory	y below, w	vhich	helped inform my treatment
decision.								

Symptoms:

1	
1	

:

Current treatments for

Treatment	Patient response	Start date

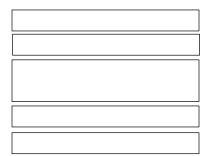
Previous treatments tried and failed:

Treatment	Patient response	Date of discontinuation	Reason for discontinuation

Please find enclosed				, which
help support my treatment	decision.			
Based on the enclosed doc	uments an	nd the information abov	e, I believe	
is medically appropriate for	r my patier	nt.		
Thank you for your time an	d for recor	nsidering the denial of		for
	. I	If you have any question	is about the request,	, or need any additional
information, please contact	t me at			. I look

forward to your response.

Sincerely,



Enclosures:



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