Sample letter of appeal

***Disclaimer**: This sample is provided for informational purposes only. Use of the information in this template letter does not guarantee that the insurance company will provide coverage and is not intended to be a substitute for, or an influence on, the independent medical judgment of the physician.*

[Physician letterhead]
[Date]
[Payer name]
ATTN: [Contact name/medical director]
[Insurance company]
[Insurance address]

Re:
[Patient first and last name]
[Patient DOB: MM/DD/YYYY]
[Insurance policy number]
[Insurance group number]

Re: Denial of coverage for [DRUG NAME]

Dear [Contact name/medical director],

I am submitting this letter to appeal the denial of coverage for [DRUG NAME] for [Patient name], dated [Date of denial]. Your organization cited [List reason(s) for denial] as the reason(s) for denial.

I ask that you review the patient information provided in this letter and reconsider the denial.

Summary of patient medical history

- [Provide a brief statement about the patient's diagnosis, medical history, and condition, including any underlying health issues that affect your treatment selection]
- [If applicable, provide:
  - A list of current and previous treatments
  - The patient's experience with treatments including the clinical outcome, adverse drug reactions, and the length of therapy
  - The reasons for not prescribing certain treatments (eg, contraindications, drug interactions, and/or lack of efficacy)]

The following supporting documentation are enclosed:

- [List each enclosed documentation; suggested enclosures: excerpts of medical and treatment records, full prescribing information of drug and note that use is within labeled indication, payer medical policy, relevant medical literature, patient history prior to physician care, Health Plan Appeal form if available, and/or letter of medical necessity if previously sent]

Based on the information provided above [include specific reasons if appropriate (eg, lack of response to other treatments)], I have determined that treatment with [DRUG NAME] is medically necessary and appropriate for [Patient name]. I respectfully request that you reconsider approving coverage for [DRUG NAME] for [Patient name].

If you have any further questions about this matter, please contact me at [Physician phone number] or via email at [Physician email]. Thank you for your time and consideration.

Sincerely,
[Physician name and credentials]