woodcock & associates

CHANGING THE WAY YOU WORK

Date

[Insurance Company's address]

To Whom It May Concern:

Thank you for the opportunity to submit this denied claim for reconsideration of payment. We are contacting you about the services rendered to [Details about the patient's name, date of service, and services rendered].

This service was denied on [Date]. The attached documentation presents the denial, as noted on the explanation of benefits we received. A subsequent communication was made over the telephone to [Name of Representative and Reference Code for call], however, this letter serves to formalize our request for reconsideration of payment.

The services rendered to the patient were denied because, according to your company, the diagnosis did not support the rendering of the service. Indeed, the service was deemed not medically necessary for the patient. For background purposes, your insurance company defines "medical necessity" as "… a term used to refer to a course of treatment seen as the most helpful for the specific health symptoms you are experiencing. The course of treatment is determined jointly by you, your health professional and XYZ HealthCare. This course of treatment strives to provide you with the best care in the most appropriate setting."

The services rendered were medically necessary for this patient. The procedure notes are attached to this letter. Dr. XYZ, the treating physician offers this statement:

[Ask that your physician dictate a professional response to the denial, addressing the medical necessity of the service. Maintain a copy of this statement and letter, in the event of future denials.]

As published in a peer-reviewed journal, the medical literature (which is attached) supports the rendering of this service in the setting in which it was rendered. Indeed, the services provided were the "course of treatment which was the most helpful for [Patient's Name] health symptoms" in the "most appropriate setting".

In addition to Dr. XYZ, the treating physician, the physician who referred the patient to our practice, Dr. ABC, supported our treatment decision. His letter of support is attached.
We believe that the service did meet your criteria for medical necessity, and is supported by other professionals in the field, as well as the patient's primary care physician.

Dr. XYZ would be more than happy to schedule a conference call to discuss this medical necessity of this case. Please contact me at 123-456-7890, if you have any questions. I will contact you in two weeks to determine your decision.

Thank you, in advance, for your reconsideration of this situation.

Sincerely,

Betty Jones
Account Representative

cc: Guarantor (Patient)

Attachments:

- EOB, with denial highlighted
- Article [write out title and journal]
- Letter from Dr. ABC

Authors' note: Areas in YELLOW must be customized by the practice in accordance with the particular situation. The insurance company will state a definition of medical necessity on its website and/or provider policy manual; use it – verbatim – for the letter. Please note that there may be form that the insurance company requires that may need to accompany this. Please also note that it is best to have a name to whom to direct the appeal. If applicable, use that contact instead of "To Whom It May Concern". The sample appeal letter does not guarantee payment, and is offered as a sample only.