Example Claims Appeal Letter

[Physician Practice Letterhead]

[Date]

[Contact] (usually the medical director)
[Title]
[Name of health insurance]
[Address]
[City, State, ZIP Code]

Insured: [Name]
Policy Number: [Number]
Group Number: [Number]

Dear Dr. [Medical director's name],

I am writing to you on behalf of my patient, [Patient name], to request reconsideration of a claim. [Drug name] was provided to [Patient name] on [Date of service]. [Patient name] has been under my care for treatment of [Diagnosis] since [Date]. You have indicated that [Drug name] is not covered by [Insurance company] because [Reason for denial from Explanation of Benefits].

Patient History and Diagnosis

Because of [Patient name]'s diagnosis, I have administered [Drug name] as a medically necessary part of [his/her] treatment. I would appreciate a reconsideration of the claim from [Date of service] for [Patient name]. To further support the medical necessity of this patient's treatment with [Drug name], I am including the following information:

[List additional information attached to appeal including product information, published data regarding clinical utility, and medical records.]

Based on the above facts, I believe treatment with [Drug name] is appropriate and medically necessary for this patient and would appreciate a reconsideration of this service. If you have any further questions, please feel free to call me at [Physician's telephone number, including area code] to discuss. Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician name]