

Sample Letter of Appeal

(Practice Letterhead)

(Date)

(Insurer Name)

(Insurer Company Name)

(City, State ZIP)

Attn: **(Name)**

(Department Name)

RE: Appeal for **(Patient Name)**
(Policy Number/Group Number/Patient ID Number)
(Date of Birth)
Treatment Date and Claim Number
Amount (Give total dollar amount of charges filed)

Dear **(Name)**:

I am writing to request a review of a denied claim for **(patient's name)**. Your company has denied this claim for the following reason(s) listed on the attached Explanation of Benefits (EOB): **(fill in reasoning from EOB)**.

(Mr./Mrs./Ms.) (patient's last name) was administered Nplate™. **(Provide dates of service, outcomes, and further rationale for Nplate™ therapy)**. Use of Nplate™ in this patient is consistent with the FDA-approved indication. Attached is the full prescribing information for Nplate™.

Nplate™ therapy has been necessary and reasonable for this patient's medical condition. I trust the information enclosed, along with my medical recommendations, will establish the medical necessity for payment of this claim.

Sincerely,

(Physician Name)

encl.