SAMPLE Letter of Appeal
For Aranesp® (darbepoetin alfa) Nephrology

Date

Payor Name
Payor Representative
Payor Address
City, State, ZIP Code
Payor Fax Number

Attention: Payor Representative
Attention: Claims Department

Re: Coverage of Aranesp® (darbepoetin alfa)
Subscriber's First and Last Name
Patient's First and Last Name
Policy Number / Patient's ID
Group Number
Patient Date of Birth
Treatment Date and Claim Number
Amount of Claim

Dear Director of Claims:

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 reason(s) from EOB}

Mr/Mrs/Ms ***{Patient's name}*** was provided with Aranesp® (darbepoetin alfa) therapy for the treatment of anemia associated with chronic renal failure.

(Provide diagnoses, dates of service, outcomes [eg, Hb levels], and rationale for treatment with Aranesp®) ***NOTE: Physicians should exercise medical judgment and discretion in regard to making an appropriate diagnosis and characterization of an individual patient's medical condition. In addition, physicians are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.***

Treatment with Aranesp® has been a necessary therapy for this patient's medical condition, and it is my clinical opinion and assessment that ***{Patient's name}*** has benefited from Aranesp®. I trust that the enclosed information, along with my medical recommendations, will establish the medical necessity for payment of this claim.

Sincerely,

{Physician's name}