[Date]
[Contact]
[Title]
[Name of health insurance company]
[Address]
[City, state, zip code]
Insured: [patient name]
Policy number: [policy number]
Group number: [group number]
Diagnosis: [diagnosis and ICD-9-CM code]

Dear [name of contact]:

This letter serves as a request for reconsideration of a claim representing charges for PROVENGE® (sipuleucel-T) administered to [patient name] on [date(s) of service]. [Patient name] has been under my treatment for his diagnosis of [diagnosis]. You have indicated that PROVENGE is not covered by [insurance name] because [reason for denial].

PROVENGE is an autologous cellular immunotherapy indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Because of [insert relevant patient information—history, diagnosis, etc], I have administered PROVENGE as a medically necessary part of this patient's treatment, and we would appreciate your reconsideration of the [date of service] claim for [patient name]. Please contact me at [physician telephone number, including area code] if you require additional information.

Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician's name]
[Physician's practice name]
Attachments [original claim form, denial/EOB, additional supporting documents]