**EMAIL TEMPLATE**

**LETTER FOR APPEALING A HEALTH INSURANCE CLAIM DENIAL**

**[Insert Your Practice/Physician Letterhead]**

Attn: **[Insert Medical Director Name]**

RE: **[Insert Patient Name]**

DOB: **[Insert Patient’s Date of Birth]**

**[Insert Name of Insurance Company]**

Policy Number: **[Insert Patient Policy Number]**

**[Insert Address]**

Claim Number: **[Insert Patient Claim Number]**

**[Insert City, State ZIP Code]**

**[Date]**

Dear **[Insert Contact Name]**:

This letter serves as the **[Select one: first/second]** appeal for approval of treatment with **[medication]** for my patient, **[Insert Patient Name].** Based on your letter of denial dated **[MM/DD/YYYY],** coverage was denied because my patient’s condition did not meet the plan’s criteria, specifically **[Insert the reason(s) provided in the denial letter].**

**[Insert Patient Name]** has been under my care for **[Insert Diagnosis] [Insert ICD-10-CM Code]** since **[Insert Date].** Treatment with **[medication]** is medically appropriate and necessary for **[Insert Patient Name]** and should be covered and reimbursed. Below, this letter outlines **[Insert Patient Name]**’s medical history, prognosis, and treatment rationale.

**[NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition. You may want to include:]**

Summary of Patient’s Medical History:

• **[Patient’s diagnosis, date of diagnosis, condition, and history]**

**• [Previous therapies used for treating the symptoms associated with the condition]**

**• [Patient’s response to these therapies]**

**• [Brief description of the patient’s recent symptoms and conditions]**

**• [Summary of your professional opinion of the patient’s prognosis and why medication is medically necessary for this patient]**

In order for me to provide appropriate care for my patient, it is important that **[Insert Plan Name]** provide adequate coverage for this treatment.

Please call my office at **[Insert primary phone number]** if I can be of further assistance or you require additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

**[Insert Physician Name and Participating Provider Number]**

 **[Insert Patient/Legal Representative Signature, if required]**