**EMAIL TEMPLATE**

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

**[Date]**

ATTN: **[Name of Contact or Medical Review/Appeals]**

**[Name of Health Insurance Company]**

**[Street Address]**

**[City, State ZIP Code]**

Insured: **[Patient First and Last Name]**

Policy Number**: [Policy Number]**

Group Number**: [Group Number]**

RE: **[Drug Name]**

Claim Denial Dear **[Name of Contact],**

This is a formal letter of appeal for reconsideration of coverage on behalf of my patient, **[Patient Name],** for **[Drug Name]** which is indicated for the treatment of **[Disease].** **[Insurance Company]** has stated that **[Drug Name]** is not covered because **[Denial Reason].** I am requesting prompt reevaluation of the claim denial for **[Drug Name]** provided to my patient on **[Date(s) of Service].**

Clinical History

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition. You may want to include the following information, as applicable:

• Brief description of patient’s age, diagnosis, prior treatments, and response to treatments

• Presentation, comorbidities, and other factors that impact the treatment decision

Rationale for **[Drug Name]**

The FDA has approved **[Drug Name]** for the treatment of **[Indication]** **[Insert supporting language from FDA- approved Prescribing Information].**

According to the explanation of benefits (EOB), **[Name of insurer/Medicare contractor]** denied this claim because **[insert reason, as stated on EOB, for denial].** This letter serves to request a formal appeal of claim **[Claim Number]** for **[Patient Name],** with policy number **[Policy Number].**

**[Explain why [Drug Name] was selected for the patient].**

Sincerely,

**[Treatment Provider’s Signature]**

**[Treatment Provider’s Name Printed]**

**[Treatment Provider’s Phone Number]**