**LETTER TEMPLATE**

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

**(Printed on Healthcare Provider Letterhead)**

Date: **[Date]**

Attn: Appeals Department

Payer Name: **[Payer Name]**

Payer Address: **[Payer Address]**

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

Payer Phone and Fax Number: **[Payer Phone and Fax Number]**

Re: Request to Appeal Insurance Denial Patient Name: **[Patient Name]**

Patient Date of Birth: **[Patient Date of Birth]**

Member ID**: [Policy Number]**

Group Number: **[Group Number]**

Dear **[Name of the Contact Person at the Insurance Company OR Appeals Department]:**

I am writing on behalf of my patient, **[Name of Patient],** to appeal **[Name of Health Insurance Company]’s** decision to deny coverage for PERTZYE® (pancrelipase) which is prescribed for the treatment of exocrine pancreatic insufficiency due to cystic fibrosis. It is my understanding based on your letter of denial dated, [Date], that coverage has been denied for the following reason(s), **[List the Specific Reason(s) for the Denial as Stated in the Denial Letter.]**

Patient History and Diagnosis

**[Provide a Brief Description of the Patient’s Medical Condition Here] [Include a Short Summary of the Patient’s Medical History]**

**[Explain why you believe it is Medically Necessary for Patient to receive this, Medicine. Examples of clinical information to include are as follows and are included at the discretion of the Healthcare Provider:**

**• Diagnosis and date**

**• Laboratory results and date**

**• Previous and current treatments/therapies]**

**[Describe the Potential Consequences of the Patient if they do not receive this medicine]**

Summary

In summary, I am requesting **[an appeal/redetermination/reconsideration]** of the denial of PERTZYE® (pancratia’s) for **[patient name].** I am requesting that you reconsider coverage based on the information provided above. I am available at my office phone **[phone number]** to address any questions or concerns regarding this appeal. Thank you in advance for your immediate attention to this written appeal.

Sincerely,

**[Physician Signature] [Physician’s Name]**

**[Physician’s Practice Name]**