**EMAIL TEMPLATE**

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

**[Physician Letterhead]**

Attn: **[Medical Director] [Insurance Company] [Address]**

**[City, State, ZIP code]**

RE: **[Patient Name]**

**[Date of Birth]**

**[Policy Number]**

**[Claim Number]**

Reference Number: **[Reference Number]**

Therapy: **[Drug Name]**

Submission Date: **[Submission Date]**

Denial Date: **[Denial Date]**

Dear Medical Reviewer/Appeals Reviewer,

On behalf of **[Patient Name]**, I am requesting a **[first-level appeal/second-level appeal]** by an Oncology Medical Advisor of the prior authorization denial of the above-referenced line item(s). It is my understanding based on a letter of denial dated **[Date]** that **[Drug Name]** has been denied because **[Quote the specific reason for the denial stated in the denial letter].**

This case involves my patient, **[Patient Name],** who was diagnosed with **[Diagnosis Name; ICD-10 Code]** on **[Date].** I believe that **[Patient Name]** would benefit from [Drug Name]. Please see the enclosed documentation that discusses **[Patient Name]’s** medical history and supporting information in more detail, as well as the use of **[Drug Name]** for **[Diagnosis Name]** and/or similar cell-type diagnosis.

The following items are enclosed:

• **[Medical literature regarding the use of Drug Name for Diagnosis name; ICD-10 Code and/or similar cell-type diagnosis]**

• **[Relevant clinical documentation such as history and physical, progress notes, treatment history, Letter of Medical Necessity]**

**• [Applicable coverage policies]**

The enclosed information supports the claim that the treatment is medically necessary. I strongly believe this request should be covered and request that you reconsider coverage based on the information provided. Due to the acute nature of this disease, I would appreciate your prompt review of this **[initial/second]** appeal.

If you have any further questions regarding this matter or need additional information, please contact my office at **[Phone Number].**

Sincerely,

**[Insert physician name and participating provider number]**