**EMAIL TEMPLATE**

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

**[Date]**

**[Contact Name]**

**[Insurance Company]**

**[Insurance Company Address]**

**[City, State ZIP Code]**

**[Fax Number]**

ATTN: Prior Authorizations/Appeals

Re: Coverage **of [Astellas Product Name/generic name/dosage form]**

**[Patient First Name]**

**[Patient Last Name]**

**[Policy Number]**

**[Group Number]**

**[Patient Date of Birth]**

Diagnosis**: [ICD‐10‐CM Code] [Diagnosis]**

Claim or Reference Number: **[Claim or Reference Number]**

Submission Date: **[Submission Date]**

Denial Date: **[Denial Date]**

To whom it may concern:

I am writing to request a review of a denial for coverage of **[Astellas Product Name]** for **[Patient Name]**.

Your company has denied this claim for the following reasons:

• **[Insert reasons]**

**[Patient Name]**’s medical history and course of treatment are as follows:

• **[Describe the patient’s history, including diagnostic test results, previous and current treatment regimens, and their outcomes]**

Based on the information provided above, the use of **[Astellas Product Name]** is medically appropriate and necessary for **[Patient Name]**. I have enclosed a copy of the Full Prescribing Information for **[Astellas Product Name].**

I respectfully request that you review the additional documentation provided and consider overturning your coverage decision regarding **[Astellas Product Name]** for **[Patient Name].** Thank you for your prompt attention to this matter. I look forward to your reconsideration. If I can provide any additional information, please contact me.

Regards,

**[Physician Name]**

**[NPI Number]**

**[Phone Number]**

**[Fax Number]**