Making a difference in Patients' lives, one Patient at a time

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Please see below a sample Appeals letter for example purposes only. This sample letter provides insight into what plans may consider relevant information regarding your patient's treatment. Please note that submitting the information below to the health plan does not guarantee they will provide coverage for the prescribed medication, and some plans may require different or additional information. This example is not meant as a substitute for a prescriber's independent medical decision-making.

{Date Created}

{Provider_Full_Name}
{Site_Address1} {Site_Address2}
{Site_City}, {Site_State} {Site_Zip}

{Contact Name} (Usually the medical director)
{Title}
{Name of the Health Insurance}
{Address Street}
{Address. City, State and Zip Code}

RE:
Insured: *{Patient Name}*
Date of Birth*: {DOB}*
Policy Number: *{Number}*
Group Number: *{Number}*
Case ID: *{Number}*

Dear Dr. *{Contact Name or Medical Director's Name}*,

I am writing to request that you reconsider your denial of coverage for *{Product Name}* which I have prescribed for my patient *{Patient First Name} {Patient Last Name}*. *{Product Name}* is FDA approved for the treatment of *{list indication}* in patients with *{diagnosis}*.

Please see Full Prescribing Information and Patient Information including additional safety information at *{Enter Product Website}*.

Your reason(s) for the denial is/are:
- *{Denial Reasons}*

Listed below are the patient's diagnosis and medical history, which confirm the medical necessity and appropriate treatment plan with *{Product Name}*. *{Patient First Name}* *{Patient Last Name}* is diagnosed with *{Diagnosis}* *{Diagnosis Code [Insert Diagnosis Code]}*. *{His/Her}* medical history is as follows:

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US-ONC-2400022

{Include Medical History}

I believe *{Product Name}* is appropriate and medically necessary for this patient and appreciate your time in reviewing and reversing your previous decision to deny coverage. If you have further questions, please do not hesitate to contact me at *{Contact Phone Number}* or *{Contact E-mail Address}*.

Sincerely,

{Prescriber's Signature}

{Prescriber's Name}