

Medical Necessity Appeal Letter Template

[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]

[Recipient Name]
[Recipient Title]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Subject: Appeal for Coverage of [Treatment/Procedure Name] – Claim
#[Claim Number]

Dear [Recipient Name],

I am writing to formally appeal the denial of coverage for [Treatment/Procedure Name], as prescribed by my primary care provider, [Doctor's Name].

This treatment was denied on [Date of Denial], as per your letter of denial stating the reason as [Reason for Denial]. I believe this decision should be reconsidered based on the medical necessity of this treatment and the specifics of my health insurance policy.

Medical Necessity Justification:

[Treatment/Procedure Name] is essential for my medical treatment and has been recommended specifically by my healthcare provider due to [describe medical condition and symptoms].

According to [Doctor's Name], this treatment is crucial because [explain why the treatment is necessary, include medical facts and how it can improve your condition or prevent deterioration].

Attached, you will find detailed statements from [Doctor's Name], along with relevant medical records and test results supporting this necessity.

Documentation Attached:

- Medical records pertaining to [relevant medical condition]
- Letter from [Doctor's Name] outlining the necessity of the treatment
- Recent studies or medical research that supports the effectiveness of the proposed treatment (if applicable)

Reference to Insurance Policy:

As per the terms outlined in my health insurance policy [Policy Number], Section [Relevant Section of Policy], it clearly states that such treatments should be covered when deemed medically necessary by the attending physician. The denial of this necessary treatment contradicts these terms.

Request for Reconsideration:

I respectfully request a thorough reevaluation of my case and prompt reconsideration of my claim. My health and well-being hinge significantly on receiving this treatment. Please review the enclosed documents and evidence supporting the medical necessity and policy coverage of this treatment.

I am willing to discuss this case in more detail and provide any further information required at your earliest convenience. Please let me know if there are any additional steps I need to undertake as part of this appeal process.

Thank you for your attention to this matter. I look forward to your prompt response. Please confirm receipt of this appeal and provide an estimated time frame for the review process.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]

Attachments:

- Medical records
- Doctor's statement
- Supporting articles/research (if applicable)