

# Coverage Reconsideration Request

Date: [Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Representative's Name],

I am writing to formally request a reconsideration of your recent decision regarding the coverage of [specific treatment, service, or medication] for my condition of [medical condition]. My policy number is [Policy Number].

On [date of denial], I received notification that my claim was denied based on [reason for denial]. After reviewing the details, I believe that this decision should be reconsidered for the following reasons:

- [Reason 1]
- [Reason 2]
- [Reason 3]

Attached are the relevant documents supporting my claim, including medical records, letters from my healthcare providers, and any other pertinent information.

Thank you for taking the time to review my request. I look forward to your prompt response to this matter.

Sincerely,

[Your Name]