Beneficiary Appeal for Reconsideration of Medical Necessity

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Re: Appeal for Reconsideration of Medical Necessity

Policy Number: [Your Policy Number]

Claim Number: [Your Claim Number]

Dear [Insurance Company Representative's Name],

I am writing to formally appeal the recent decision regarding my claim for [specific medical treatment or service]. I believe this service is medically necessary for my health condition, which has been documented by my healthcare provider.

On [date of original decision], I received notice that my claim was denied on the basis of [reason for denial]. I have attached documentation from my healthcare provider, including [list documents: e.g., treatment plan, medical records, etc.], which support the medical necessity of the requested services.

I respectfully request that you reconsider the denial based on the enclosed information. I trust that you will review my case thoroughly to ensure that all aspects of my healthcare needs are addressed.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Name]

Enclosures: [list any enclosed documents]