Letter of Appeal for Reconsideration of Service Coverage

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

[Insurance Company Name]
[Claims Department]
[Company Address]
[City, State, ZIP Code]

Dear [Claims Adjuster's Name],

I am writing to formally appeal the denial of coverage for [specific service or treatment] as stated in your letter dated [date of denial letter]. My policy number is [policy number].

The reason provided for the denial was [insert reason for denial]. I believe that this decision should be reconsidered because [explain your reasoning, including supporting medical information or documentation].

Enclosed, please find [list any supporting documents you are including, such as medical records or letters from healthcare providers]. I kindly ask that you review this information and reconsider your decision regarding my coverage.

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

Sincerely,

[Your Signature (if mailing a hard copy)]
[Your Printed Name]