Appeal Letter for Medical Coverage Determination

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Claims Department Address]

[City, State, Zip Code]

Subject: Appeal for Denied Medical Coverage - [Claim Number]

Dear [Insurance Company or Adjuster's Name],

I am writing to formally appeal the denial of coverage for my recent medical procedure, [name of procedure], that took place on [date]. The claim number for this procedure is [claim number].

The denial letter dated [date of denial letter] stated that the procedure was not medically necessary. However, my healthcare provider, [Provider's Name], has detailed the medical necessity in their letter, which I have included with this appeal.

As a patient diagnosed with [specific condition], the treatment is essential for my health and well-being. I believe that the medical documentation provided supports the necessity of this coverage, and I urge you to review the attached documentation thoroughly.

Thank you for your attention to this matter. I look forward to your prompt response and hope for a positive resolution.

Sincerely,

[Your Name]

[Your Policy Number]

Attachments:

- Denial letter
- Provider's medical necessity letter
- Medical records