Request for Reconsideration of Temporary Disability Benefits Amount

Date: [Insert Date]

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

[Recipient's Name]
[Insurance Company/Agency Name]
[Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request a reconsideration of the amount of temporary disability benefits awarded to me following my claim submitted on [Insert Claim Date]. My claim number is [Insert Claim Number].

Upon reviewing the determination letter received on [Insert Date of Determination Letter], I believe that the amount stated does not adequately reflect my current circumstances, including my medical condition and the financial impact I am experiencing.

Attached to this letter, you will find supporting documentation, including medical records and a detailed breakdown of my expenses.

I appreciate your attention to this matter and look forward to your prompt response. Please do not hesitate to contact me at [Your Phone Number] or [Your Email Address] should you require any further information.

Thank you for your consideration.

Sincerely,

[Your Name]