Appeal for Allergy Medication Reassessment

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient Name]

[Recipient Title]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Recipient Name],

I am writing to formally appeal the recent decision regarding my allergy medication coverage. My name is [Your Name], and my insurance policy number is [Policy Number]. I have been prescribed [Medication Name] by my [Doctor's Name], who is a specialist in [Specialty], for the treatment of [Allergy Condition].

Despite following the initial treatment plan, my symptoms have not improved, and it has become evident that a reassessment of my medication is necessary. I believe that [Medication Name] is essential for my health and well-being, and I respectfully request that you reconsider the decision made on [Date of Decision].

Enclosed with this letter are supporting documents including my medical records, a letter from my doctor, and any other relevant information that demonstrates the need for this medication.

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

Sincerely,

[Your Name]