# Claim Appeal Letter

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Insurance Company Name]

[Claims Department Address]

[City, State, Zip Code]

## Subject: Appeal for Denied Disability Claim [Claim Number]

Dear [Claims Adjuster's Name],

I am writing to formally appeal the denial of my disability claim, reference number [Claim Number]. I received your notification dated [Denial Date], stating that my claim was denied due to [Reason for Denial]. I believe this decision requires reconsideration based on the following reasons:

1. [First reason for appeal, including supporting evidence]
2. [Second reason for appeal, including supporting evidence]
3. [Additional reasons if necessary]

Enclosed are copies of my medical records and other documentation that support my appeal. I kindly request a thorough review of my claim and the inclusion of this new information in your evaluation.

Thank you for your attention to this matter. I look forward to your prompt response. Please feel free to contact me at [Your Phone Number] or [Your Email Address] should you require any further information.

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]

Enclosures: [List of attached documents]