Health Insurance Pre-Authorization Denial Response

Date: [Insert Date]

Provider Name: [Insert Provider Name]

Provider Address: [Insert Provider Address]

City, State, Zip: [Insert City, State, Zip]

Policyholder Name: [Insert Policyholder Name]

Policy Number: [Insert Policy Number]

Dear [Provider Name],

We are writing to inform you that the pre-authorization request for [specific treatment/service] submitted on [insert date of submission] has been denied. The reason for this denial is [insert brief explanation or denial reason].

Please review our denial details as outlined below:

- **Denial Reason:** [Provide reason]
- **Coding Error:** [Specify if applicable]
- **Policy Exclusions:** [List exclusions if applicable]
- **Other Information:** [Any additional relevant information]

If you believe this decision is in error, you may appeal by submitting additional documentation or clarification of the services provided. Please send your appeal to [insert appeal address and contact information].

Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Title]
[Insurance Company Name]
[Contact Information]