

# Health Plan Coverage Denial Notification

Date: [Insert Date]

Member Name: [Insert Member Name]

Member ID: [Insert Member ID]

Address: [Insert Member Address]

## **Subject: Denial of Coverage for Prescribed Medications**

Dear [Member Name],

We are writing to inform you that your recent request for coverage of the following prescribed medications has been denied:

- Medication Name: [Insert Medication Name]
- Medication Name: [Insert Medication Name]

The reason for this denial is as follows:

[Insert specific reason for denial, e.g., not included in the formulary, lack of medical necessity, etc.]

You have the right to appeal this decision. Should you choose to do so, please refer to the instructions outlined in your member handbook or contact our customer service for further assistance.

We understand that this may be disappointing news, and we are here to help you understand your options for alternative treatment and medications.

Thank you for your attention to this matter. If you have any questions, please do not hesitate to contact our member services team at [Insert Contact Information].

Sincerely,

[Your Name]

[Your Title]

[Health Plan Name]