Medical Report Appeal Letter

Date: [Insert Date]

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

To Whom It May Concern,

I am writing to formally appeal the decision regarding my health services request. My name is [Your Name], and my [Insurance/Health Services Provider] ID number is [ID Number].

On [Date of Initial Decision], I received a notification stating that my request for [specific service or treatment] was denied due to [reason for denial]. I respectfully disagree with this decision for the following reasons:

- [Reason 1]
- [Reason 2]
- [Reason 3]

Enclosed are relevant documents, including my medical report from [Doctor's Name] and any supporting evidence for your review.

I kindly request that you reconsider my case and approve the necessary health services required for my treatment. Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Name]
[Your Signature (if sending a hard copy)]