

Request for Independent Medical Review

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Adjuster's Name],

I am writing to formally request an independent medical review regarding my claim with reference number [Insert Claim Number]. After reviewing the initial determination made by your office, I believe that a second opinion from an independent medical expert is necessary to ensure a fair and comprehensive evaluation of my case.

My healthcare provider, [Provider's Name], has documented my condition, which includes [Briefly describe your medical condition and treatment received]. However, the determination made on [Insert Date of Initial Decision] does not take into account [Mention any specific concerns or reasons].

In accordance with my rights under [Applicable State or Federal Law], I would appreciate if you could initiate an independent medical review at your earliest convenience. I am including copies of relevant medical records and correspondence for your reference.

Please confirm the receipt of this request and provide information regarding the next steps in the review process. Thank you for your attention to this matter.

Sincerely,

[Your Name]