

# Dispute of Health Insurance Coverage Decision

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Subject: Contesting Coverage Denial for [Policy Number]

Dear [Claims Department/Specific Contact Name],

I am writing to formally contest the decision made regarding my recent claim [Claim Number] for [specific treatment or service] that was denied on [date of denial]. I believe this decision was made in error and would like to request a comprehensive review.

According to my policy, [briefly outline the relevant coverage terms]. I have attached the necessary documentation, including [list any included documents such as medical records, invoices, and previous correspondence].

I kindly request that you revisit this decision, taking into account the information provided. I believe that this treatment is not only necessary but is also covered under my current health plan.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]