

Request for Reconsideration

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]

Subject: Request for Reconsideration of Claim #[Claim Number]

Dear [Claims Adjuster's Name],

I am writing to formally request a reconsideration of the denial of my health insurance claim, referenced above. The claim was submitted on [Submission Date] for [brief description of services or treatment].

The reason provided for the denial, as stated in the notification received on [Denial Date], was [mention denial reason]. However, I believe that this decision needs to be reviewed due to the following reasons: [briefly outline your reasons and include any supporting documents].

Enclosed are [list any attached documents, e.g., medical bills, diagnosis letters, etc.] to support my request. I would greatly appreciate your prompt attention to this matter.

Thank you for your reconsideration of my claim. I look forward to your response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]