Letter of Support for Health Insurance Appeal

Date: [Insert Date]

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

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Dear [Claims Reviewer/Appropriate Recipient],

I am writing to formally appeal the denial of coverage for [specific treatment, procedure, or service] provided on [date of service] for [Patient's Name]. This treatment is critical for [Patient's Name]'s [specific medical condition], as outlined by [Doctor's Name/Provider's Name].

Enclosed, you will find supporting documentation including:

- Medical records and notes from [Doctor's Name]
- A letter of medical necessity
- Relevant test results
- Previous approval letters

Based on the medical evidence and recommendations from [Doctor's Name], this treatment is essential for [Patient's Name]'s health and well-being. Denying this coverage adversely affects [his/her/their] quality of life and could lead to further complications.

I respectfully request a reconsideration of this claim and the prompt approval of coverage for the recommended treatment. Thank you for your attention to this matter and for your consideration of [Patient's Name]'s healthcare needs.

Sincerely,

[Your Name]
[Your Relationship to Patient, if applicable]