Health Insurance Claim Appeal

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Re: Appeal of Denial for Prescription Medication Claim

Policy Number: [Your Policy Number]

Claim Number: [Claim Number]

Dear [Insurance Company Contact/Claims Department],

I am writing to formally appeal the denial of coverage for my prescription medication, [Medication Name], which was prescribed by my healthcare provider, [Provider's Name], on [Date of Prescription]. The denial was communicated to me on [Date of Denial] and the reason provided was [Reason for Denial].

This medication is essential for my treatment of [Medical Condition] and has been deemed medically necessary by my doctor. [Optional: Include any relevant medical history or information that supports your claim.]

According to my policy, [mention any specific policy clauses that support your case]. I believe that the denial does not align with the terms of my coverage.

I have attached the following documents to support my appeal:

- Copy of the denial letter
- Medical records from [Provider's Name]
- Prescription details

- Any additional supporting documents

Thank you for your attention to this matter. I respectfully request a prompt review of my claim and look forward to your favorable response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]