[Your Name]

[Your Address]

[City, State, ZIP Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Company Address]

[City, State, ZIP Code]

Subject: Appeal Against Denial of Health Benefits

Dear [Claims Department/Specific Person's Name],

I am writing to formally appeal the denial of my health benefits for [specific treatment/procedure], which was denied on [date of denial]. My policy number is [policy number], and the claim number associated with this denial is [claim number].

The reason given for the denial was [reason for denial]. I respectfully disagree with this decision as [provide your argument against the denial, citing specific policy provisions, medical necessity, etc.].

Please find attached the relevant documentation supporting my case, including [list of documents such as medical records, letters from healthcare providers, etc.].

I kindly request that you review my case again and reconsider your decision regarding my health benefits. It is critical for my [health condition/situation], and I believe it falls under the coverage as stipulated in my policy.

Thank you for your attention to this matter. I look forward to your prompt response. Should you need any further information, please do not hesitate to contact me.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]