

Appeal for Medical Procedure Waiver

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Your Email]

[Your Phone Number]

[Recipient Name]

[Recipient Title]

[Insurance Company/Hospital Name]

[Address]

[City, State, ZIP Code]

Dear [Recipient Name],

I am writing to formally appeal the decision made on [date of decision] regarding the denial of my request for a waiver for the [specific medical procedure]. My insurance reference number is [insert number].

[Provide a brief description of your medical condition and the necessity of the procedure. Explain why the waiver is essential for your health and well-being. Include any supporting details or documentation.]

Given the circumstances described, I kindly request that you reconsider my appeal. I believe that with the additional information provided, you will find that the waiver is justified for my situation.

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

Sincerely,

[Your Name]