

Appeal for Reimbursement for Extended Hospital Stay

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Representative],

I am writing to formally appeal the denial of reimbursement for my extended hospital stay at [Hospital Name] from [Start Date] to [End Date]. My insurance policy number is [Policy Number].

During my hospitalization, I received essential medical care due to [briefly describe medical condition]. The initial authorization covered a certain duration; however, my condition required an extended stay for proper treatment. Attached are the medical records and statements from my healthcare provider, Dr. [Doctor's Name], which validate the necessity of the extra days.

As such, I respectfully request that you review my case and reconsider the denial of coverage for the additional days in the hospital. I believe this request will align with the policy provisions for necessary inpatient care.

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

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]