Health Insurance Denial Appeal

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Subject: Appeal for Denial of Coverage - [Policy Number]

Dear [Insurance Adjuster's Name],

I am writing to formally appeal the denial of coverage for [specific treatment/service] for my condition [condition name], as referenced in your letter dated [denial date]. My policy number is [policy number].

Upon reviewing your decision, I believe that the denial was made in error because [explain reasons for appeal]. Enclosed are supporting documents, including [list any relevant documents such as medical records, provider letters, etc.].

I kindly request a prompt review of my case and a reconsideration of the coverage for the necessary treatment. Thank you for your attention to this matter. I look forward to your response.

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]