

# Health Insurance Denial Appeal Letter

Your Name: [Your Name]

Your Address: [Your Address]

City, State, Zip Code: [City, State, Zip Code]

Email: [Your Email]

Phone Number: [Your Phone Number]

Date: [Date]

Insurance Company Name: [Insurance Company Name]

Claims Department Address: [Claims Department Address]

City, State, Zip Code: [City, State, Zip Code]

## **Subject: Appeal for Denial of Coverage for Diagnostic Tests**

Dear Claims Department,

I am writing to formally appeal the denial of coverage for diagnostic tests that were performed on [Date of Service]. The reference number for this claim is [Claim Number]. I understand that the claim was denied due to [specific reason for denial]. However, I would like to provide additional information and request a reconsideration of this decision.

[Briefly explain the medical necessity of the diagnostic tests and any supporting information, including doctor's referrals or recommendations.]

It is my understanding that these tests are essential for accurate diagnosis and treatment of my condition. The tests were ordered by my physician, [Doctor's Name], who can be reached at [Doctor's Phone Number] for any further clarification.

Enclosed, please find copies of the relevant documents, including:

- Medical records
- Test results
- Doctor's notes

I appreciate your attention to this matter and request a prompt review of my appeal. Please feel free to contact me at [Your Phone Number] or [Your Email] should you require any more information.

Thank you for your consideration.

Sincerely,

[Your Name]

[Your Policy Number]