

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

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

Dear [Claims Adjuster's Name or "To Whom It May Concern"],

I am writing to formally appeal the denial of coverage for my recent claims related to [specific treatment or service] dated [date of service]. According to your letter dated [date of denial letter], my claim was denied on the grounds of pre-existing conditions.

I would like to contest this decision for the following reasons:

- [Reason 1: Explain why the denial is unjustified]
- [Reason 2: Provide further evidence or documentation to support your claim]
- [Reason 3: Mention any relevant laws or regulations that support your position]

Please find attached copies of [list documents included, such as medical records, letters from doctors, etc.] which support my appeal.

I respectfully request a thorough review of my case and reconsideration of the decision to deny coverage for treatment related to my pre-existing condition. I look forward to your prompt response to this appeal.

Thank you for your attention to this matter.

Sincerely,

[Your Name]