Letter of Appeal for Denied Prescription Medication Coverage

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Representative/Department],

I am writing to formally appeal the denial of coverage for my prescription medication, [Medication Name], as stated in your letter dated [Date of Denial Letter]. My member ID is [Your Member ID].

The denial was based on [briefly state reason for denial, e.g., "it being deemed not medically necessary"]. However, after consulting with my healthcare provider, Dr. [Provider's Name], I believe that this medication is essential for my treatment of [condition/diagnosis]. This medication has been prescribed to manage my symptoms and improve my overall health.

I have attached supporting documents, including a letter from Dr. [Provider's Name], relevant medical records, and any other necessary forms, to substantiate my case. I kindly request that you review this information and reconsider my request for coverage of [Medication Name].

Thank you for your attention to this matter. I look forward to your prompt response and a resolution of this appeal. Please feel free to contact me at [Your Phone Number] or [Your Email Address] if you require any further information.

Sincerely,

[Your Name]