Health Insurance Network Participation Appeal

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

To: [Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Subject: Appeal for Participation in Health Insurance Network

Dear [Insurance Company Name] Team,

I am writing to formally appeal the decision regarding the exclusion of my healthcare provider, [Provider's Name], from your health insurance network. As a longstanding policyholder with [Policy Number], I believe that [Provider's Name] offers essential services that are vital to my health and well-being.

[Provide a brief explanation of your situation, including any relevant medical history or reasons why the provider is essential for your care.]

Given these circumstances, I kindly request a review of my appeal and consideration for including [Provider's Name] in your network. This will not only ensure that I receive quality healthcare but also maintain continuity in my treatment plan.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Name]