Disability Appeal Letter

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Recipient Name]

[Office/Agency Name]

[Office Address]

[City, State, Zip Code]

Dear [Recipient Name],

I am writing to formally appeal the decision made regarding my disability benefits application, dated [insert application date]. My application was denied on [insert denial date], and I believe this decision should be reconsidered based on the following reasons:

[Briefly explain your reasons for the appeal, mentioning any new medical evidence or changes in your condition that support your claim.]

I have attached relevant documents for your review, including [list documents such as medical records, treatment summaries, etc.]. I urge you to take these into consideration as you review my case.

Your assistance in this matter is greatly appreciated, and I hope to resolve this issue promptly. Please feel free to contact me at [your phone number] or [your email address] should you need further information.

Thank you for your attention to my appeal. I look forward to hearing from you soon.

Sincerely,

[Your Name]