Prescription Error Appeal Letter

Date: [Insert Date]

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Dear [Insurance Company Representative's Name],

I am writing to formally appeal the denial of coverage for my prescription medication dated [Insert Prescription Date], for [Medication Name]. My insurance claim number is [Insert Claim Number].

On [Date of Denial], I received a notice stating that my claim was denied due to a prescription error. I believe this decision may have been made in error due to the following reasons:

- [Reason 1: Description of the error or misunderstanding]
- [Reason 2: Evidence or additional context]
- [Reason 3: Any relevant supporting information]

Attached are documents that support my appeal, including [list any attached documents, such as a new prescription, doctor's notes, etc.].

Given the circumstances, I kindly request that you reconsider my claim for coverage of this necessary medication. If you require any further information to assist in your review, please do not hesitate to contact me.

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

Sincerely,

[Your Name]