

Insurance Pre-Authorization Appeal

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]

Subject: Appeal for Pre-Authorization Denial - [Claim Number]

Dear [Insurance Company Contact Name],

I am writing to formally appeal the denial of pre-authorization for [specific treatment/procedure] on [date of denial]. The denial was based on [brief description of the reason for denial].

I believe this decision should be reconsidered due to the following reasons:

- [Reason 1]
- [Reason 2]
- [Reason 3]

Attached are supporting documents including [list documents such as medical records, letters from doctors, etc.] that substantiate the medical necessity for the requested treatment.

I appreciate your attention to this matter and look forward to your prompt response. Please feel free to contact me at [your phone number] or [your email] for any further information.

Sincerely,

[Your Name]

[Your Policy Number]