

Insurance Pre-Authorization Appeal

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

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

Subject: Appeal for Pre-Authorization Denial for Specialty Medication

Dear [Claims Representative's Name or "To Whom It May Concern"],

I am writing to formally appeal the recent denial of pre-authorization for the specialty medication [Medication Name], prescribed by my healthcare provider, Dr. [Provider's Name], for the treatment of [Medical Condition].

The denial, communicated in your letter dated [Date of Denial], cited [Reason for Denial]. However, I believe this decision is inconsistent with my medical needs and the clinical guidelines. [Briefly explain the medical necessity for the medication and any supporting facts.]

Enclosed you will find the following documentation to support my appeal:

- Letter of medical necessity from Dr. [Provider's Name]
- Relevant medical records
- Clinical guidelines supporting the use of [Medication Name]
- Any additional supporting documents

I kindly request a thorough review of my case. It's critical for my health to have access to this medication. I appreciate your attention to this matter and look forward to your prompt response.

Thank you for your understanding.

Sincerely,
[Your Name]
[Policy Number]
[Group Number]