Insurance Pre-Authorization Request 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]

Re: Pre-Authorization Request Appeal for [Patient's Name] - Policy Number: [Policy Number]

Dear [Insurance Company Representative's Name],

I am writing to formally appeal the denial of the pre-authorization request for [specific treatment or procedure] for [Patient's Name], which was submitted on [date of initial submission].

The treatment is medically necessary as documented in the attached physician's letter and medical records. [Briefly explain why the treatment is necessary and any relevant details, such as previous treatments or diagnoses.]

We kindly request that you reconsider this decision based on the additional information provided. [Mention any specific policy terms or clinical guidelines that support your case.]

Thank you for your attention to this important matter. We appreciate your prompt review of this appeal and look forward to your response.

Sincerely,

[Your Name]

[Your Title, if applicable]

[Your Relationship to the Patient]

[Your Signature (if mailing a hard copy)]

Attachments: [List any attached documents such as medical records, letters from healthcare providers, etc.]