

# Insurance Pre-Authorization Review Appeal

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

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

Dear [Claims Reviewer's Name],

I am writing to formally appeal the denial of pre-authorization for [specific treatment/service/procedure] for my [condition/diagnosis] dated [date of denial]. My policy number is [policy number].

The reason stated for the denial was [Insert denial reason]. I believe this decision is incorrect due to [brief explanation of your reasoning, including any supporting facts, medical necessities, or policy stipulations].

Attached are the following documents to support my appeal:

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

I kindly request that you review this information and reconsider the decision on the pre-authorization for the necessary treatment. Timely intervention is critical for my health, and I appreciate your prompt attention to this matter.

Thank you for your consideration.

Sincerely,

[Your Name]