

Insurance Reimbursement Appeal

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Policy Number: [Insert Policy Number]

Claim Number: [Insert Claim Number]

Dear [Insurance Company Representative's Name],

I am writing to formally appeal the denial of coverage for the ongoing management of my chronic illness, [Insert Illness Name]. My healthcare provider, [Provider's Name], has recommended [specific treatment or therapy], which is crucial for my health and well-being.

The denial letter dated [Insert Denial Letter Date] indicated that [briefly state the reason for denial]. I respectfully disagree with this decision for the following reasons:

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

Additionally, I have attached supporting documents that include:

1. Medical records from [Provider's Name]
2. Letters of medical necessity
3. Relevant clinical guidelines that support the treatment

Given these circumstances, I urge you to reconsider my claim for coverage of the aforementioned treatment. This support is essential for managing my condition and improving my quality of life.

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

Sincerely,

[Your Name]

[Your Address]

[Your Phone Number]

[Your Email Address]