Prescription Refill Appeal Letter

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company/Claims Reviewer],

I am writing to formally appeal the denial of my prescription refill for [Medication Name] (Prescription Number: [Insert Number]). My initial request dated [Insert Date] was denied on [Insert Date of Denial] due to [Insert Reason Given for Denial].

This medication is critical for my health and well-being as it is prescribed by my physician, Dr. [Doctor's Name], who can be reached at [Doctor's Phone Number]. After evaluating my condition, he has determined that continuous treatment is necessary for managing my [insert condition].

I kindly request a reconsideration of my prescription refill request based on the following points:

- [Point 1: Reason/Supporting Information]
- [Point 2: Additional Information]
- [Point 3: Any Relevant Documentation]

Attached are any relevant medical documents including my prescription history, clinical notes, and letters from my healthcare provider that support my need for this medication. I urge you to review these documents and grant approval for my refill.

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

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]