Appeal for Medical Treatment Denial

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Insurance Company Name]

[Claims Department Address]

[City, State, Zip Code]

Dear [Insurance Company Representative's Name],

I am writing to formally appeal the denial of coverage for [specific treatment or service] that was recommended by my healthcare provider, [Provider's Name]. The denial, dated [Date of Denial], references [specific reason for denial].

As per my medical history, I have been diagnosed with [medical condition], and this treatment is essential for my health and recovery. I believe that the denial is not justified based on the medical necessity outlined by my physician in the attached documents.

Enclosed with this letter, you will find supporting medical documentation, including letters from my doctor and records that clearly explain why this treatment is necessary for my condition.

I respectfully request that you review my case again and reconsider the decision. I am looking forward to a prompt resolution of this matter and appreciate your attention to this important issue.

Thank you for your time and consideration. I can be reached at [Your Phone Number] or [Your Email] should you require any additional information.

Sincerely,

[Your Name]