Supplemental Insurance Claim Reconsideration Request

Date: [Insert Date]

Your Name: [Insert Your Name]

Your Address: [Insert Your Address]

Your Policy Number: [Insert Your Policy Number]

Your Contact Information: [Insert Phone Number and Email]

To Whom It May Concern,

I am writing to formally request a reconsideration of the denial for my supplemental insurance claim, referenced by claim number [Insert Claim Number]. The claim was denied on [Insert Date of Denial], and I believe that there may have been an oversight or misunderstanding in the evaluation process.

According to the documents I submitted, [Briefly explain the reason for the claim, any additional evidence, and why you believe the claim should be approved].

Enclosed are copies of all relevant documents, including [list the documents, e.g., medical bills, treatment records, etc.], which support my case for the mentioned claim.

I kindly ask that you review my claim again and consider the additional information provided. I appreciate your attention to this matter and look forward to your prompt response.

Thank you for your time.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]