Health Insurance Claim Appeal

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

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

Subject: Appeal of Claim Denial - [Claim Number]

Dear [Claims Department/Specific Person's Name],

I am writing to formally appeal the denial of my health insurance claim, referenced above, which was originally submitted on [date of submission] for [description of services rendered].

My claim was denied on [date of denial] due to [reason for denial]. I believe this decision warrants a review because [reason for appeal, e.g., "the services were medically necessary as prescribed by my physician, Dr. [Physician's Name]"].

In support of my appeal, I have included [list any attached documents, e.g., "a letter from my physician, medical records, and any additional relevant documentation"].

I respectfully request that you reconsider this claim and approve the payment for the services rendered. Please let me know if any additional information is needed to assist in the review process.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]