Healthcare Expense Reimbursement 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 for Reimbursement of Prescription Medication

Dear [Insurance Adjuster's Name],

I am writing to formally appeal the denial of my claim for reimbursement of prescription medication, specifically [Name of Medication], for the date of treatment [Date]. The reference number for my claim is [Claim Number].

The medication was prescribed by my healthcare provider, Dr. [Doctor's Name], due to [Brief Explanation of Condition]. This medication was essential for my treatment and well-being, as documented in the attached medical records.

Upon reviewing the denial letter dated [Denial Letter Date], it was indicated that the claim was denied due to [Reason for Denial]. I believe this decision may have been made in error, as [Explain Your Reasons for Dispute].

Attached are the relevant documents supporting my appeal, including:

- Prescription from Dr. [Doctor's Name]
- Receipts for the medication
- Medical records related to my condition

I kindly request a reevaluation of my claim for reimbursement. Please let me know if you require any further information or documentation to assist with my appeal.

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

Sincerely,

[Your Name]