*[ Your Name ]*

*[ Your Address ]*

*[ Insurance Plan’s Address for Appeals ]*

*Note: You can find this on your denial notice, in your benefits book, or by calling your plan.*

*[ Date ]*

 Re: *[ Name of Person Whose Claim or Bill Was Denied ]*

 Insurance ID: *[ Enter the insurance ID # for the person whose claim was denied ]*

 Date of Birth:  *[ Enter the birth date for the person whose claim was denied ]*

 Claim Number: *[ You can find this on your explanation of benefits or denial letter ]*

 Date of Service: *[ This should be on documents from your plan or on your bill ]*

 Provider*: [ Name of doctor and/or hospital ]*

To Whom It May Concern:

I write to appeal your denial or partial denial of the treatment or payment for the treatment described above. These services were medically necessary. Please find enclosed a letter from my doctor [ *and medical records, if applicable* ] supporting my appeal.

[ *In the next paragraph or two,* *describe* *your condition and the treatment. How do you feel when you miss treatments? How does the treatment make you feel better? What kinds of things can you do with the help of the treatment that you can’t do without it? What other treatments did you try that didn’t work? Tell your story and explain why the treatment is important to you and how it is beneficial.* ]

As a result, please cover this [ *denied service* ]. Thank you for your attention to this matter. If you have any questions, please call me at [ your phone number ].

Sincerely,

*[ Your Name ]*

*[Attachments:] [List of Attachments, if any]*