Appeals & Grievance Department

*[ Insurance Plan Name ]*

*[ Insurance Plan Address ]*

*[ Date ]*

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

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

Date of Service: *[ This should be on documents from the insurer or on the bill ]*

To Whom It May Concern:

I write on behalf of my patient, *[ patient’s name ],* who has been under my care for

*[ amount of time ]*. *[ S/he ]* suffers from *[ diagnosis(es) ]*. To treat these conditions, I have *[recommended/performed] [treatment/prescription/item/service].*

This recommended treatment is medically necessary for the following reasons:

*[ Describe your reasons for recommending this treatment. Please refer to our “Four Tips for Writing an Effective Letter of Medical Necessity.” This is the part of your letter where you need to convince the reader that this treatment is necessary and appropriate. This may be more than one paragraph, if needed. ]*

Please reconsider your denial of this *[ denied service ].* Thank you for your prompt attention to this matter. If you have any questions, please call me at *[ phone number ].*

Sincerely,

*[ Your Name ]*

*[ Your Title ]*

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