

This Example Letter is for demonstration purposes only. Use of this Example Letter or the information in this Example Letter does not guarantee coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional.

<Date>

ATTENTION: <Medical Director Name and/or Medical Review/Appeals>

<Payer/Health Plan Name>

<Payer Address>

REGARDING: Denied <Claim/Prior Authorization> for <Product Name>

PATIENT NAME: <Patient Name>

DATE OF BIRTH: <Patient Date of Birth>

POLICY ID NUMBER: <Policy ID Number>

PROVIDER ID NUMBER: <Provider ID Number>

Dear <Medical Director Name and/or Medical Review/Appeals>,

I am writing to appeal the denied <claim/prior authorization> for <Product> for my patient, <Patient Name>, who has been diagnosed with <diagnosis>. <Payer Name> has denied my patient's <claim/authorization request> due to <insert denial reason(s) listed on Explanation of Benefits or denial letter received from payer>. Attached to this request are clinical notes regarding this patient's disease state <list any other relevant supporting documentation, as applicable>. Consider attaching the following documents as appropriate: US Food and Drug Administration (FDA) approval letter (if Product was recently approved and/or has not yet been added to the payer's formulary), <Product Name> Prescribing Information, and any documentation related to the patient's disease state, relevant testing, and/or treatment for the patient's condition.

<Product Name> is indicated for <indication from Prescribing Information>.

<Rationale for treating the patient with <Product Name>. In this rationale, you may wish to include patient's diagnosis and disease state, including any therapies the patient is currently using or has previously used, and contraindications to any other relevant therapies; comorbid health issues; and any other factors that have influenced your treatment decision. A statement of medical necessity may also be required.>

Thank you for taking the time to read this letter. I believe that treatment with <Product Name> is appropriate for this patient. I look forward to your prompt review of this request. My office may be reached at <office phone number> if any additional information is required.

Best regards,

<Healthcare Provider Signature>

<Healthcare Provider Name>