MEDICAL APPEAL LETTER

DATE

Recipient Name
Position
Department
Insurer Company Name
Street address
City, State Zip Code

RE: [Insert Patient Name]
DOB: [Insert Patient's Date of Birth]
Policy Number: [Insert Patient Policy Number]
Claim Number: [Insert Patient Claim Number]

Dear Mr./Mrs./Ms. [Recipent's last name]

I'm writing this letter to appeal against your decision to deny my $6,740 claim for an appendix operation. Based on your letter of denial dated [date], coverage was denied because [reason for denial].

I believe that your decision is improper because the treatment received was recommended by Doctor, Dr. King Lion as outlined below;

- [Your diagnosis, date of diagnosis, condition, and history]
- [Previous therapies used for treating the symptoms associated with the condition]
- [Your response to these therapies]
- [Brief description of your recent symptoms and conditions]
- [Summary of Dr. Lion's professional opinion of your prognosis and why the operation is medically necessary for you]

Enclosed with this letter is Dr. lion's recommendation for medication.

Based on the foregoing, I humbly request that you reconsider your decision and approve my claim.

Please let me know if you need any more information from me or my medical provider to review my claim.

Sincerely