(Paste this on your letterhead)

Today's Date

Insert address for payer/claims appeal department

RE:
Insured:
Patient:
ID #:
Date of service:
Claim #:

To Whom It May Concern:

This letter is to request an appeal of your denial for payment on the attached claim. All services in question have been performed; A) In accordance with generally accepted standards of medical practice and satisfy the overarching criteria used to determine "Medical Necessity"; B) Are clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and C) Are not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

_____ (Insert Doctor's Name) made the determination to perform the service based on his/her extensive knowledge as a _____ (Insert Specialty), personal evaluation of the patient, and accepted standards of medical practice.

We have provided documentation outlining the rationale behind the performance of _____ (insert what was performed).

We have also provided as additional evidence for why the service/procedure was medically necessary [Local coverage determination, articles from peer-reviewed journals, second opinions from other physicians, or other supporting material].

Based on all the documentation we have provided, we expect payment in full for the attached claim. Based on our submitted charge and your allowable, we are owed $xx.xx. Should you have any questions or require additional information, please contact me at (xxx) xxx-xxxx.

Thank you for your time and reconsideration of this matter.

Sincerely,

Your title

Practice name