Sample Letter of Appeal for [Product Name]

This sample letter is a guide to help you write an appeal for the coverage denial of a medication by your patient’s health insurance. It is for informational purposes only and does not constitute medical, legal, or reimbursement advice and represents no statement,

promise, or guarantee of coverage or payment. Always check to see if the patient’s health insurance has their own template for you to follow when submitting a letter of appeal. Individual health insurance policies are frequently updated and it is the responsibility of the provider and/or their office staff to determine appropriate coding, medical necessity, site of service, and documentation requirements, and to submit appropriate codes, modifiers, and charges for services rendered, as specified by the patient’s health insurance.

[Date of service]

ATTN:

[Name of health insurance company] [PO Box or street address]

[City], [State] [Zip code] [Phone]

[Fax]

RE:

[Patient name] [DOB]

[Parent/Legal guardian’s name] Policy number: [Policy number] Group number: [Group number]

Medicaid number (if applicable): [Medicaid number] Claim/Case number: [Claim/Case number]

Subject: Appeal for coverage denial of [Product name] Dear [Payer medical director/contact name],

I am writing to appeal a claim that was denied for my patient, [Patient name] . In a letter dated [month]/[date]/[year], [name of health insurance company] stated that [Product name] was not covered for my patient due to [reason(s) for denial] [which is/are] listed in the Explanation of Benefits [attached].

I have reviewed this letter and, based on my medical expertise, ask that you reconsider this decision. [Product name] was approved by the US Food and Drug Administration (FDA) on [month]/[date]/[year] for [Product indication] [(please see attached [Product Name] Prescribing Information and FDA Approval Letter)].

[Patient name] was diagnosed with [Diagnosis name] on [month]/[date]/[year] and has been under my care since [month]/[date]/[year]. Below is [Patient name] ’s medical history and current course of treatment:

[Patient’s name] ’s medical history:

Description of [Patient’s name] ’s current symptoms that support diagnosis:

Current treatment regimen include(s):

|  |  |  |
| --- | --- | --- |
| **Name of treatment** | **Patient response** | **Start date** |
|  |  |  |

Previous treatment include(s):

|  |  |  |
| --- | --- | --- |
| **Name of treatment** | **Patient response** | **Date of discontinuation** |
|  |  |  |

[Patient name] has experienced an inadequate response while being on the treatment plan listed above. Based on my assessment and in my clinical opinion, [Product name] is medically appropriate for my patient.

I trust that the enclosed information will establish the medical necessity for approval of this claim. If additional information is required for this request, please contact my office immediately using the information below.

Thank you very much for your attention to this very important matter. I look forward to your response and approval of this treatment request.

Sincerely,

[Physician name] [Credentials] [Physician address] [Physician phone number] [Physician email address]

**Enclosures** [suggested]

[Product name Prescribing Information] [Product name FDA Approval Letter] [Relevant medical records, clinical trials data]

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