Sample Reauthorization Letter of Appeal for [Product Name]

This sample letter is a guide to help you write an appeal to a reauthorization denial by your patient’s health insurance for continuing treatment with their prescribed medication. 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 reauthorization 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: Reauthorization appeal for coverage denial of [Product name]

Dear [Payer medical director/contact name],

I am writing to appeal a denial for reauthorization for my patient, [Patient name]. In a letter dated [month]/[date]/[year], [name of health insurance company] stated that [Product name] was not approved for reauthorization 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. [Patient name] was approved to start treatment with [Product name] on [month]/[day]/[year]. It is my medical judgment that [Patient name] should continue [Product name] at the [currently prescribed dose/ newly prescribed dose] based on [reason(s) for change or no change]. Since starting [Product name], my patient has experienced [specific clinical outcomes].

I have included supporting evidence from [Patient name]’s last clinic visit. The treatment goal(s) with continuation of [Product name] [is/are] [treatment goal(s)]. If [Product name] is stopped, [Patient name] may experience [clinical outcomes if treatment is stopped]. The patient’s caregiver, [Caregiver name], has also reported that [Patient name] has experienced an improvement in [treatment outcomes seen by the caregiver].

Based on my assessment and in my professional opinion, it is important for [Patient name] to continue treatment with [Product name]. 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 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 request to continue treatment.

Sincerely,

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

**Enclosures** [suggested]

[Product name Prescribing Information] [Product name FDA Approval Letter] [Explanation of Benefits]

[Relevant medical records, clinical trials data]

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