Template and Instructions for Appeals Letter

PURPOSE:
This template is your guide to writing an appeals letter to your insurance company in response to their decision to deny your medication.

The template below represents typical information for an insurance carrier. Insurance carriers could require more or less information than what is included in this template. Including this information does not guarantee insurance coverage or a positive result. The template below is provided for reference purposes only. Your appeals letter should align with your clinical records, personal treatment history, and medical needs.

INSTRUCTIONS:
Fill in the blue text with your information or details supporting your claim. The blue text is meant to guide your answer. You will need to change it to meet your needs.

If you cannot identify or locate any of this information, ask your Hub Case Manager for help.

REMEMBER:
Delete anything in blue that is not being used in your case. When finished writing, change the blue text to black. Before sending this letter to your Case Manager, **DELETE THIS INSTRUCTIONS SECTION.** Your letter should start with the date.

Date

Your full name
Your full address
Your city, state, and zip code
Your phone number with area code
Your email address

Insurance provider's name
Insurance provider's address
Insurance provider's city, state, and zip code

Dear (name of insurance provider):

My doctor recently prescribed (medication name) to treat my (condition). This prescription was denied coverage on (insert date) by your company because of (insert reason for denial from denial letter). My policy number is (insert number). I am writing this letter to appeal that decision.

I am asking that you cover (medication name) because (explain the impact your condition has on your life. For example, "I am unable to work, and I can't walk around the block." List as many examples as you can to show how your condition limits what you are able to do).

I have been prescribed other medications to treat my condition, but they have not worked or have stopped working for me. (List these medications, how long you took them, and the results the medication(s) had on treating your condition.)

My doctor is submitting a Letter of Medical Necessity that outlines why the medication that was prescribed is medically necessary for me. As I am not a healthcare provider, I will leave that job to (him/her). I would like to add though, that Dr. (your doctor's name) knows my situation, my condition, and my needs, and would not have prescribed (medication name) unless it was going to offer me a chance for a better outcome than previous therapies. For me to be able to receive this medication in a timely manner and benefit from the treatment my doctor has recommended, please provide a determination by (insert date).

Thank you so much for your attention to and consideration of this appeal. I know time is important in this process, so if there are any more materials or information that I can provide to help with the appeal, please let me know and I will do my best to submit them.

Sincerely,

Your first and last name

Policy information:
Policy holder name: (insert name)
Patient name: (insert name, even if it is the same as above)
Policy number: (policy number)

Attachments:
Denial letter
[List any more files or PDFs that you will be attaching to this letter to support your appeal, such as copies of preauthorizations, second opinions, or treatment guidelines/published journal articles demonstrating outcome benefits and treatment success with (medication name)].