PHYSICIAN APPEAL TEMPLATE FOR MEDICAL INSURER DENIAL
(Letter Will Be Reviewed By Medical Insurance Physician)

(To be reviewed/edited/approved by your doctor, printed on his/her letterhead, signed, and sent directly to patient's insurance company appeals departement.)

Date

Name of Patient
Patient's Medical Insurer
Patient's Subscriber Number
Patient's Plan Number

Dear Colleague:

I am writing this letter to support the need of my patient, _____, for _____ needed for _____. My patient's medical history is as follows: _____
_____
_____
_____.

(Patient's name) has been under my care since _____ for _____ (include medical diagnostic code number for medical condition.)

In my opinion, his/her need for _____ has been demonstrated to be clearly beneficial/needed because (reason/s; i.e. less likely to develop infection, treatment/medication more effective, long-term assessment demonstrates cost savings can be attributed to this recommended medication/test/therapy/surgery, or other explanation as appropriate.)

(Patient's name) will require _____ (quantity of medication/specific type of therapy/type of operation) for _____ (specify quantity/frequency/surgical procedure/other description as appropriate.)

I appreciate your consideration of this medically necessary request. If you have any questions, feel free to contact me at telephone number _____ or fax number_____.

_____
Physician's Signature
Physician's Title (if appropriate)