REIMBURSEMENT PATIENT APPEAL LETTER TEMPLATE

This document can be used as a guide to assist with creating your own patient appeal letter

[Date]

Attn: Director of Claims [Or Insert Other Name]

[Insurance Company Name]

[Address]

[City, State and ZIP Code]

Re: [Patient’s Name]

Policy: [Group Number/Policy Number]

Treatment Dates: [Date Of Service]

Amount: [Total Charges]

Dear [Mr/Ms/Director of Claims name, If Available],

You recently denied a claim on the grounds that the care provided by [Name of Provider] at [Name Of Treating Facility] on [Date Of Services] was not medically necessary.

[Patient Name] is experiencing pain in [part of body] [describe pain].

[Patient Name] has already undergone the following treatments [describe treatments].

The explanation of benefits did not give adequate information to establish the validity of the denial decision and thus, I am appealing the denial. Please provide the following information to support the denial of this treatment.

* Name and credentials of the representative who reviewed the treatment records
* Outline of the specific records reviewed and a description of any records that would be necessary in order to approve the treatment
* Copies of any expert medical opinions that have been secured by your company regarding treatment of this nature so that Dr [Name Of Provider] may respond to its applicability to patient’s condition

Please review this claim again. If you need further information or a medical report, please inform me within 10 days.

I can be reached at the following telephone number: [Your Phone Number]

Thank you for your prompt attention to this matter.

Sincerely,