**Template and Instructions for Appeals Letter**

**PURPOSE:**

This template is to assist you in writing an appeals letter to your insurance company in response to their decision to deny your medication.

The template below includes information that may be helpful when appealing a denial from an insurance carrier. Be sure to review your insurance carrier’s requirements, as they may differ from the information provided in this template. The template below is provided for reference purposes only. You should consult with your insurance policy/plan to determine what information is relevant for your case. This may include your clinical records, personal treatment history, and medical needs. You should also consult with your healthcare provider, who may be sending documentation to your insurance carrier as well. Your letter, in addition to the documentation your healthcare provider submits, may help support the appeals process. Neither your submission of a letter nor your healthcare provider’s submission of documentation is a guarantee of insurance coverage or a positive result.

**REMEMBER:**

Anything in magenta should be deleted and replaced with your responses. If the magenta text does not apply, delete the sentence. Before sending this letter to your insurance carrier/ Case Manager, **DELETE THIS INSTRUCTIONS SECTION.** Your letter should start with the date.

<<Date>> Name: <<Patient’s Name>>

<<Health Plan Name>> DOB: <<XX/XX/XXXX>>

ATTN: <<Department>> Patient Policy ID Number: <<Policy #>

<<Health plan address>>

Re: Letter of Appeal for <<medication name>>

Dear <<Name of insurance provider>>,

My doctor recently prescribed <<medication name and dose>> 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 <<insert an explanation of the impact your condition has on your life, and 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. I have previously been on: Insert list of these medications and how long you took them>>

My doctor is submitting the necessary documents that outline why they believe the medication that was prescribed is medically necessary for me. For me to be able to receive this medication in a timely manner and potentially benefit from the treatment my doctor has prescribed, please provide me with a timeline of when a determination will be reached.

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,

<<Patients first and last name>>

**Policy Holder information:**

Policy holder name: <<first and last name>>

Patient Address: <<insert patients full address including zip code>>

Patient Phone number: <<insert phone number>>

Patient Email Address: <<insert email address>>

Policy Number: <<insert 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 prior authorizations and/or second opinions]

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