<Date>
<Payer Name><Payer Address>
<Payer City, State and Zip>

Re: <Patient's Name>
<Type of Coverage>
<Group Number/Policy Number>

Date of Service	HCPS Code	Claim Number	Billed Amount	Denial Date

To Whom It May Concern:

I am requesting a First-Level Appeal/Second-Level Appeal by a <Rheumatology> Medical Advisor of the denial of the above-referenced line item(s). It is my understanding based on your Letter of Denial dated <Insert Date> that <Drug Name> has been denied because: <Quote the specific reason for the denial stated in denial letter>

The case in question involves a patient with <ICD-10 Code> <Diagnosis Name> using a treatment regimen of <Drug Name>. The enclosed documentation relates to the use of <Drug Name> for <ICD-10 Code><Diagnosis>.

The following items are enclosed:

- Medical literature regarding the use of <Drug Name> for <ICD-10 Code> <Diagnosis Name>
- Relevant clinical documentation such as: history and physical, progress notes, treatment history, Letter of Medical Necessity (LOMN)
- Copies of the EOBs
- Compendia listings and/or coverage policies if applicable

In view of the above information found in the appeal packet attached, I believe all claims should be covered and paid.

Sincerely,

<Provider Signature>
<Provider Name>