

[Your letterhead]

[Date]

[Address for payer/claims appeal department]

RE:

Insured:

Patient:

ID #:

Date of service:

Claim #:

To Whom It May Concern:

This letter is being sent to appeal the denial of the above listed patient for payment of the attached claim.

The Explanation of Benefits your company has provided indicates the service we provided the patient was not medically necessary.

_____, **MD or PA/NP** decided to perform the service based on the fact they are a qualified provider of healthcare services as well as their first-hand evaluation of the patient.

Attached, please find a copy of the medical record, which provides sufficient evidence to support the medical necessity of the services provided this patient and why _____ **MD or PA, NP** found the service to be medically necessary.

I have also attached for your review, **[articles from peer-reviewed journals, second opinions from other physicians, or other supporting material]**.

With the additional information and explanation for why we provided these services for your beneficiary and our patient, we expect payment in full for our claim. The total amount we are owed is _____. If you have any questions, please feel free to call me at _____. Thank you for your time and reconsideration of this claim.

Respectfully,

[Your name]

[Title]

[Practice name, city, state]