Sample Appeal Letter for Pre-Authorization Denial

[Date]

[Insurance Company Name]
[Appeals and Grievances Department]
[123 Apple Street]
[Anytown, VA 12345]

RE: **[Your Name]**
[Member ID #]
[Reference # on Denial Letter]
[Your Date of Birth]

HELPFUL TIPS

Make copies of everything you send with your appeal for your records. If you are sending your appeal by mail, ensure you send it with tracking. If faxing, be certain to verify successful transmission of the fax.

To Whom it May Concern at **[Insurance Company Name]**:

My name is **[patient]** and I am a policyholder of **[insurance company]**. I am writing to file an appeal regarding **[insurance company name's]** denial of a pre-authorization for **[treatment name]**. I received a denial letter dated **[provide date]** stating **[provide denial reason directly from letter]**.

As you are aware, I was diagnosed with **[diagnosis name]** on **[date]**. I experience significant impact to my daily life due to **[explain symptoms]**. I am currently under the care of **[doctor name]** at **[facility name]**. He/She has explained in his/her attached Letter of Medical Necessity why he/she feels this **[treatment]** is clinically beneficial for me. He/she states, "**[provide statement from letter that supports treatment]**." Please refer to his/her letter for more significant medical history.

Please reconsider the previous adverse decision and allow coverage of **[treatment]** as my treatment should begin as soon as possible. Please thoroughly review the provided documents and contact me at **[your phone number]** or my physician at **[doctor's phone number]** should there be additional supporting information you require to make a decision. Thank you for your time and assistance in this matter, and I look forward to a positive decision from you soon.

Respectfully,

[Your Name]
[Your Address]

Enclosures:
1. Denial Letter From Plan
2. Doctor's Letter of Medical Necessity
3. Medical Records
4. Supportive Journal Articles

CC: **[Name of Treating Doctor]**