

**Sample Letter of Appeal
Physician's Letterhead**

Please Note: By downloading materials from this website, you agree to all of the following. These materials are available for download and public personal use. These materials have no value and are not to be re-sold or repurposed. They are solely for your personal use. No purchase from or relationship with IPSEN is required to download or use these materials. IPSEN makes no representations or warranties about these materials or their fitness for any specific use. IPSEN is not responsible for any changes made to these template documents. All billing and coding decisions are the responsibility of the relevant physician. IPSEN does not guarantee any specific reimbursement or favorable results.

[Insurance Company]	Re:	[Patient Name]
[Address]		[Policy #]
[City, State, Zip]		[DOB]
		[Address]
		[City, State, Zip]

To Whom It May Concern:

I am writing to appeal the denial of benefits for the use of **[Product name (generic name)]** for services requested for **[Patient Name, ID#, Group #]**. Included in this letter of appeal are information on the treatment rationale, medical records, medical necessity data and medical studies confirming **[Product name (generic name)]** as an effective treatment for the diagnosis of **[Diagnosis and ICD10 Code]**

Treatment Rationale

[Provide information on patient response to past treatments and anticipated prognosis and rationale for now prescribing Product name (generic name)]

Outline of Medical Studies

[Outline a brief overview of the studies evaluating the use of Product name (generic name) in this condition and/or patient population]. Remember to include the FDA approved indications and usage.

Medical Record Information

[Highlight key dates and entries of the medical record how supporting Product name (generic name) use]

Per the included medical information, it is my professional opinion that **[Product name (generic name)]** is medically necessary in treating the patient and the denials for the patient's use of the drug should be reversed. Please call my office at **[Office Phone Number]** if I can provide further information or speak with a review board to appeal the denial of coverage decision. I look forward to reaching resolution of overturning the denied status of **[Product name (generic name)]** for this patient.

Sincerely,

[Physician name]

[Phone number]

Enclosure: [Original denial notification copy]