Insured:
Policy Number:
Re: Dates of service

To whom it may concern:

I am writing on behalf of my patient, , to request that approve coverage and appropriate payment associated with 's treatment of with . has indicated that is not covered because . This letter provides information about the patient's medical history, diagnosis, and medical necessity of the treatment provided.

We are requesting that you approve payment for for . Should you require additional information, please contact me.

Patient History and Diagnosis

is a -year-old with a diagnosis of . has been treated previously with and . We prescribed to on and are requesting an appeal of 's coverage decision.

The attached medical records document 's clinical condition and medical necessity for treatment with . Based on the above facts, I am confident that you will agree that is indicated and medically necessary for this patient. Please refer to the enclosed Prescribing Information for . If you have any further questions regarding this matter, please do not hesitate to call me at . Thank you for your prompt attention to this matter.

Sincerely,

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Enclosures:
- Prescribing Information (PI)
- Copies of medical records