Sample Letter of Addressing Denied Claims

[Physician letterhead]

[Date]

ATTN: Medical Director/Medical Reviewer/Appeals

[Payer Name]

[Payer Address]

[Payer City, State, ZIP]

RE: <<Patient Name>>
<<Type of Coverage>>
<<Group Number>>
<<Policy Number>>

Reference Number	Therapy	Submission Date	Denial Date
[Reference Number]	[Therapy/Drug Name]	[Submission Date]	[Denial Date]

Dear Medical Director Name/Medical Reviewer/Appeals,

I am requesting a first-level/second-level appeal by an Oncology Medical Advisor of the denied claim for [Patient Name] as referenced above. It is my understanding based on your letter of denial dated [Date] that [Therapy/Drug Name] has been denied because [Quote the specific reason for the denial stated in the denial letter].

The case in question involves my patient, [Patient Name], with [ICD-10 Code] [Diagnosis Name] using a treatment regimen of [Therapy/Drug Name]. The enclosed documentation relates to the use of [Therapy/Drug Name] for [ICD-10 Code] [Diagnosis] and/or similar cell-type diagnosis.

The following items are enclosed:

- Medical literature regarding the use of [Therapy/Drug Name] for [ICD-10 Code] [Diagnosis name] and/or similar cell-type diagnosis
- [Relevant clinical documentation such as history and physical, progress notes, treatment history, Letter of Medical Necessity (LOMN)]
- [Copies of the Explanation of Benefits (EOB)]
- [Compendia listings and/or coverage policies, if applicable]

The information provided in the appeal packet attached establishes medical necessity of [Therapy/Drug Name] for this patient. Please contact my office at [Insert phone number] if I can provide you with any additional information.

Thank you for your time and consideration,

[Provider Signature]
[Provider Name]