It Matters
Empowerment Pathways

Sample Appeal Letter for Claim Denial

[Date]

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

RE: **[Your Name]**
[Member ID #]
[Reference # on Explanation of Benefits]
[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 wish to file an appeal concerning **[insurance company name's]** denial of a claim for **[procedure name]**. I received an Explanation of Benefits dated **[provide date]** stating **[provide denial reason directly from letter]**.

As is evident from my previous medical claims, I was diagnosed with **[migraine/chronic migraine]** on **[date]**. Unfortunately, there is significant impact to my daily life as evidenced by **[explain symptoms]**. I am currently under the care of **[doctor name]** at **[facility name]**. In the Letter of Medical Necessity I attached, he/she outlined why this **[procedure]** is clinically beneficial for me. He/she states, "**[provide statement from letter that supports treatment]**." Please consult his/her letter for more significant medical history. As well, I have included supplemental materials regarding the nature of the procedure and some additional details about the procedure itself and the efficacy of it for my condition.

Please thoroughly review the provided documents and reconsider the previous adverse decision to allow coverage of **[procedure]**, as this treatment was necessary to my health. Should there be additional supporting information you require to render a positive decision, please do not hesitate to contact me at **[your phone number]** or my physician at **[doctor's phone number]**. Thank you for your attention in this matter. Your prompt consideration to this appeal is appreciated.

Respectfully Yours,

[Your Name]
[Your Address]

Enclosures:
1. Explanation of Benefits document dated [date]
2. Doctor's Letter of Medical Necessity
3. Medical Records
4. Documents explaining procedure and its efficacy
5. Supportive Journal Articles

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