<Date>
<Payer Name>
<Payer Address>
<Payer City>, <Payer State> <Payer Zip Code>

Regarding: <Patient First Name> <Patient Last Name>
Member Number: <Member ID #>

<Date of Service> <CPT Code> $<Billed Amount> #<Claim Number> <Denial Date>

To Whom It May Concern:

Please accept this letter as a request for reconsideration of the denial of the above referenced line item(s) for <Patient First Name> <Patient Last Name>. It is my understanding based on your letter of denial <insert date> that this medication was denied based on <insert reason>.

I am submitting the following information for reconsideration:

- ❑ Medical Information showing the use of <Drug Name> for <ICD-10> <Diagnosis Name> <Diagnosis Code> diagnosis
- ❑ Clinical documentation such as: patient's history, physical, chart notes, and initial date of diagnosis
- ❑ Copies of the Explanation of Benefits (EOBs)
- ❑ Previous treatment given: list of medications, procedures and treatments with clinical response and failures

I believe all claims should be covered and paid in light of the information I have included with this letter.

Sincerely,

<Provider Signature>
<Provider Name>