Letter of Appeal

***Patient Name
***Patient DOB

***Health Plan Name
***Health Plan Fax Number

Health Plan ID: ***
Denial Reference #: ***
Date of Denial: ***

Re: Appeal for Prior Authorization Denial

To whom it may concern,

I am writing to appeal the prior authorization denial for the treatment of ***(insert drug name) for ***(patient name) for ***(include diagnosis and severity). This patient has been under my care since ***(add date).

Your letter provided the following reason for the denial: ***(include reason for denial)

Despite this, I believe that ***(medication) at ***(dosage, frequency) is the most appropriate therapy for this patient due to the following reasons:

[The provider should offer a detailed rationale for the treatment, including medical justification, evidence-based guidelines, or relevant clinical studies.]

Here is a brief summary of the patient's relevant medical history:

***(add in past trials, intolerances, courses of steroids, exacerbation history, ED visits/hospitalizations)

***(allergies, if any)

With this information, I kindly request that you reconsider the coverage of ***(medication) for my patient. Please contact me at ***(phone number) if you require any additional information in support of this appeal. I look forward to your prompt consideration and timely approval.

Sincerely,

***(Prescriber name, Specialty and NPI)