SAMPLE Letter of Appeal

Date of request: [Date]
[Request for Expedited Review]

ATTN: Prior Authorizations/Appeals
[Contact name]
[Health plan name]
[Health plan address]
[City, State ZIP Code]
[Fax number]

RE: Appeal for Denial of [Product Name]
[Insured Patient First Name Patient Last Name]
Date of birth: [Month Day, Year]
[Policy #][Group #]
Diagnosis: [ICD-10-CM Code][Diagnosis]
[Claim or Reference # (if known)]
Submission date: [Submission date] Denial date: [Denial date]

To whom it may concern:

My name is [Provider First Name Provider Last Name, medical specialty (National Provider Identifier number)], and I am writing on behalf of [Patient First Name Patient Last Name] to appeal the denial of coverage for [Product Name].

[Patient name] has been in my care since [date] for the treatment of [FDA-approved indication].

In a letter dated [date of denial letter], coverage for [Product Name] was denied due to [reason(s) for denial stated in denial letter]. I have reviewed your letter and, based on my medical expertise, believe that [Product Name] is the appropriate [transdermal] treatment for [patient name] because [rationale for prescribing Product Name].

Based upon my clinical judgment, I request that you consider approving [Product Name] for my patient. I have enclosed additional documentation to further support the medical necessity of [transdermal treatment with] [Product Name] for [patient name]. My office can be contacted at [phone number] or [email address] if additional information is required to overturn this decision.

Thank you in advance for your timely attention to this matter.

Sincerely,
[Physician name, medical specialty(National Provider Identifier number)]

[Physician address]
Phone number: [Physician phone number]
Fax number: [Physician fax number]
Enclosures [for consideration]:
[Relevant patient medical records]
[Letter of Medical Necessity]
[Prescribing Information]
[FDA Approval Letter(s)]
[Peer-reviewed literature (eg, treatment guidelines)]

This sample letter and related information are provided for informational purposes only. It is the responsibility of the health care provider and/or their staff, as appropriate, to determine the correct diagnosis, treatment protocol, and content of all such letters and related forms for each individual patient and submit. Noven Pharmaceuticals does not guarantee coverage or reimbursement for the product.

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