

SAMPLE LETTER OF DENIAL APPEAL

[Date]
[Payer Name]
[Payer Address]
Attn: [Appeals Department]

Re: [Patient Name]
[policy number]
[claim number, if applicable]
[date of service]

Dear [Medical Director]:

I am writing to request an appeal of a Panzyga® claim denial for [Patient Name], DOB: [Patient DOB]. The reason for the denial, which was explained on [explanation of payment or remittance advice], was [reason(s) for denial]. I disagree with this decision and request that this claim be approved.

[Exercise your independent medical judgment and discretion when describing patient's history, diagnosis, and current condition; providing a summary of your professional opinion of the patient's likely prognosis or disease progression without treatment with Panzyga®; etc]

My patient, [Patient Name], DOB: [Patient DOB], has responded to Panzyga® therapy and I believe treatment was medically justified. I request that you reconsider this claim and approve this new therapy.

Please call my office at [telephone number] if you require any additional information or documentation. I look forward to your timely response.

Sincerely,

[Physician Name]
[Telephone number]

Enclosures [to be determined by physician]

[This document is provided as a sample template that may be used to appeal a payer coverage decision. The physician is responsible for the content of the letter that is customized to include information concerning an individual patient.]

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