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/an [CUTAQUIG®, OCTAGAM®, 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 the 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 CUTAQUIG, OCTAGAM, or PANZYGA, etc]

My patient, **[Patient Name]**, **DOB: [Patient DOB]**, has responded to [CUTAQUIG, OCTAGAM, PANZYGA] therapy and I believe the 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 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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