

SAMPLE LETTER OF APPEAL FOR PRIOR AUTHORIZATION DENIAL

To the prescribing healthcare provider: When determining whether treatment is appropriate for a patient, please refer to the product's full Prescribing Information.

IMPORTANT NOTE:

This letter provides an example of the types of information that may be provided when appealing a prior authorization denial from a patient's health plan.

Use of the information in this letter does not guarantee that the health plan will provide reimbursement and is not intended to be a substitute for or an influence on the independent medical judgment of the physician. Please make sure to review the health plan's instructions to determine whether additional enclosures, such as appeal forms, chart notes, test results, and supporting literature, may also be necessary.

KEY REMINDER:

Use this sample letter as a guide to create a letter of appeal on the treating physician's letterhead.

SAMPLE LETTER OF APPEAL FOR PRIOR AUTHORIZATION DENIAL

[Date]

[Name]

[Insurance Company Name]

[Address]

[City, State, Zip Code]

ATTN: Prior Authorizations/Appeals Department

Re: Coverage of [PRODUCT Name]
[Patient First and Last Name]
[Insurance Policy Number]
[Insurance Group Number]
[Patient Date of Birth]
Diagnosis: [Diagnosis and Code]

To whom it may concern:

The purpose of this letter is to appeal a prior authorization denial and request reconsideration of coverage for [PRODUCT Name] for [Patient Name].

[My office] [My patient] received a notice indicating that [health plan name] has denied this [prior authorization/coverage request] on [date of denial letter] for the following reasons:
[Insert reasons provided in denial letter.]

[Patient Name]'s medical history and previous and current treatment is consistent with the following:

[Provide a Brief Description of the Patient's Medical Condition Here]

[Include a Short Summary of the Patient's Medical History]

[Explain why you believe it is Medically Necessary for Patient to receive this Medicine]

[Describe the Potential Consequences of the Patient if they do not receive this Medicine]

[Obtain and Attach Supporting Letters of Medical Necessity from any Specialist that is or has provided Care to the Patient]

[Include Medicine Indication Information]

[Include Medicine Administration Information]

The information I have provided above justifies the use of [PRODUCT Name] [dose/frequency], for [Patient Name], substantiating that it is medically appropriate and necessary. Enclosed is a copy of the full Prescribing Information [Please insert or attach the full Prescribing Information with this fax or mail submission] for [PRODUCT Name], which serves to further substantiate the use of [PRODUCT Name] for this patient.

I ask that you please review the documentation provided and consider reversing your coverage denial of [PRODUCT Name] for [Patient Name].

I appreciate your prompt attention to this matter and look forward to your reconsideration of this authorization request. If you need additional information, please contact me at (physician phone number).

Sincerely,

[Physician Name]

[NPI Number]

[Practice Name (if applicable)]

[Address]

[Phone Number]

[Fax Number]