UNITED RHEUMATOLOGY

Appeal of Denial of Claims Letter

[Your name]
[Your address]
[Your city, state, ZIP]
[Your phone number]

[Date]

Attn: Director of Claims
[Name of insurance company]
[Insurance company address]
[City, state, ZIP]

Re: Patient: [patient name]
Policy: [insurance policy number]
Insured: [name of patient or insured person]
Treatment dates: [admission date] - [discharge date]
Amount: [total charges]

Dear [Mr./Ms./Director of Claims name, if available],

You recently denied a claim on the grounds that the care provided by [name of provider] on [date of services] was not medically necessary.

Denial of this claim was not justified and I am appealing the denial. The explanation of benefits did not give adequate information to establish the validity of this decision. Therefore, please provide the following information to support the denial of this treatment.

Please furnish the name and credentials of the insurance representative who reviewed the treatment records. Also, please provide an outline of the specific records reviewed and a description of any records that would be necessary in order to approve the treatment.

Also, please furnish copies of any expert medical opinions that have been secured by your company regarding treatment of this nature so that the treating physician may respond to its applicability to [my/this patient's condition].

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Please review this claim again. The information is correct [or has been corrected] to reflect the appropriate diagnosis and treatment. If you need further information or a medical report, please inform me within 10 days.

I can be reached at the following telephone number(s):

Daytime: [your phone number]
Evening: [your phone number]

Thank you for your prompt attention to this matter.

Sincerely,