Sample Letter of Appeal

Claim number: [Claim number]
Submission date: [Date]
Denial date: [Date]

[Physician's letterhead]

[Date]

[Prior authorization department or contact name]
[Name of health insurance company]
[Insurance company's address]
[City, state, ZIP code]

Patient: [Patient's name]
Patient ID: [Patient's plan-specific member ID]
Date of birth: [Patient's date of birth]
Policyholder: [Policyholder's name]
Group number: [Policyholder's group number]
Diagnosis: [ICD-10-CM code or diagnosis]

ATTN: Prior Authorization/Appeals Department

To whom it may concern,

My name is [Physician's name], and I am writing on behalf of my patient, [Patient's name], to request a review of your denial of coverage for [Product name]. [Patient's name] has been under my care for the treatment of [Patient's condition].

I understand that the reason for your denial is [copy reason verbatim from the plan's denial letter]. However, in my opinion, [Product name] is the appropriate treatment for my patient.

In support of that judgment, I will share the patient's relevant clinical history. [Provide a brief medical history, including diagnosis, allergies, existing comorbidities, and International Classification of Diseases (ICD) code(s)].

[Discuss rationale for using product vs other treatments. Insert your recommendation summary here, including your professional opinion of your patient's prognosis or disease progression without this treatment]. See below for the list of enclosed documents that support this view. Based on this information, I ask that you provide coverage of [Product name] for my patient.

Please feel free to contact either me at [Physician's phone number] or [Patient's name] at [Patient's phone number] for any additional information you may require. My patient and I look forward to receiving your timely response and approval of this claim.

Thank you for your time and consideration.

Sincerely,

[Physician's signature]

[Physician name] [Physician NPI] [Name of practice]
[Physician's phone number]
[Physician's fax number]
[Physician's email address]

Enclosures: [List and attach additional documents, which may include Prescribing Information, clinical notes/medical records, US Food and Drug Administration approval letter, clinical studies and efficacy data, and/or clinical practice guidelines.]

This letter is provided as an example and is meant for educational purposes only. Mirati Therapeutics cannot guarantee insurance coverage or reimbursement. Coverage and reimbursement may vary significantly by payer, plan, patient, and setting of care. It is the sole responsibility of the health care provider to include the proper information and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient.