

Sample Physician Appeal Letter

Please note, this is NOT a form letter and should be customized for your patient's specific situation. You can use the suggestions in the brackets as a guide.

[Date]

[Name]

[Insurance Company Name]

[Address]

[City, State ZIP]

Re: [Patient's Name]

[Patient's insurance member number]

[Group number/Policy number]

[Type of Coverage]

[Type of service denied and date of denial from EOB]

[Reason for denial from EOB]

Dear [Name of contact person at insurance company],

It is my understanding that [Patient's name] has received a denial for [name of procedure] because it is believed that the procedure is [state specific reason for the denial found on the EOB, e.g., not medically necessary, experimental, etc.]

[Patient's name] has been under my care since [date] for the treatment of type 1 diabetes [T1D]. Since that time, [patient's name] has [include a brief overview of patient's treatments and T1D management protocol, e.g., the number of finger stick tests, insulin injections, or how frequently a pump is used. Include a brief medical history emphasizing the most recent events that directly influence your decision to recommend the denied therapy along with any peer-reviewed information, [like this](#), that may support your request]. The service denied is critical in managing [patient's name]'s condition and access to this treatment will help improve [his/her] health outcomes by making it easier for [him/her] to manage and adhere to the recommended treatment plan.

For this reason I am writing to provide you with information regarding [name of denied procedure]. [Give a brief, yet specific description of the procedure and why you believe it should be approved and include a specific counter point to the reason noted in the denial on the EOB. Include potential downside of treatment not being covered like worsening A1C levels or additional out-of-pocket costs for more expensive alternatives. Find more helpful pointers in the chart in the "Denials and Appeals" resource].

I ask that you overturn the denial and provide coverage for [denied treatment or service] based on the information above. I believe therapy should begin on [date]. Should you have any questions, please do not hesitate to call me at [phone number].

Sincerely,
[Physicians' Name]

Sample Patient Appeal Letter

Please note, this is NOT a form letter and should be customized for your specific situation. You can use the suggestions in the brackets as a guide. If your physician is also submitting a letter on your behalf, you'll want to ensure the information in your letter also aligns. See more helpful tips in the "Denials and Appeals" resource.

[Date]

[Name]

[Insurance Company Name]

[Address]

[City, State ZIP]

Re: [Your Name]

[Your insurance member number]

[Group number/Policy number]

[Type of Coverage]

[Type of service denied and date of denial from EOB]

[Reason for denial from EOB]

Dear [Name of contact person at insurance company],

I [or my loved one] recently received a denial for [name of procedure] because it is believed that the procedure is [state specific reason for the denial found on the EOB i.e., not medically necessary, experimental, etc.]

[I or my loved one's name] have been under care for Type One Diabetes [T1D] since [date]. Since that time, [I or my loved one] has [include a brief overview of patient's treatments and T1D management protocol i.e., the number of finger stick tests, insulin injections, or how frequently a pump is used. Include a brief medical history emphasizing the most recent events that directly support your request along with any peer-reviewed information, [like this](#)]. The service denied is critical in managing [my or my loved one's] condition and access to this treatment will help improve [my or my loved one's] health outcomes by making it easier for [me or my loved one's] to manage and adhere to the recommended treatment plan.

For this reason I am writing to provide you with information regarding [name of denied procedure]. [Give a brief, yet specific description of the procedure and why

you believe it should be approved and include a specific counter point to the reason noted in the denial on the EOB. Include potential downside of treatment not being covered like worsening A1C levels or additional out-of-pocket costs for more

expensive alternatives. Find more helpful pointers in the chart in the “Denials and Appeals” resource].

I ask that you overturn the denial and provide coverage for [denied treatment or service] based on the information above. I believe therapy should begin on [date]. Should you have any questions, please do not hesitate to call me at [phone number].

Sincerely,
[Your Name]

Sample Exception Letter

Note, your insurance company may have a standard form, which is what you should use if it is available. This template should only be used if your insurance company does not have a standard form to request exceptions. Make sure to check with an insurance company representative before you begin. This is NOT a form letter and should be customized for your specific situation. You can use the suggestions in the brackets as a guide.

[Date]

[Name]

[Insurance Company Name]

[Address]

[City, State ZIP]

Re: [Patient's Name]

[Patient's insurance member number]

[Group number/Policy number]

[Type of Coverage]

[Type of service denied and date of denial from EOB]

[Reason for denial from EOB]

Dear [Name of contact person at insurance company],

I am writing to request an exception that my plan cover [medication/device/service] as it is not currently covered [for me or my loved one] [or includes a different brand than I use] by [plan name].

I have had Type One Diabetes [T1D] since [date]. Since that time, I have [include a brief overview of your treatments and T1D management protocol i.e., the number of finger stick tests, insulin injections, or how frequently a pump is used, along with a brief medical history emphasizing the most recent events that directly influence your need of the not included medication/device/service. Incorporate any evidence of using the covered drug or treatment as some plans may require you to have tried the covered insulin and provide evidence that your T1D worsened under the covered brand before approving coverage for the requested brand of insulin].

The [medication/device/service] approved by the FDA on [date] is critical in managing my condition and access to [medication/device/service] is imperative to manage and adhere to the recommended treatment plan. [Provide medical-based data to illustrate how the medication/device/service is key to improving A1C levels, hypoglycemic events, or how it helps you better manage your condition or contain costs for more expensive alternatives. You may also consider including a peer-

reviewed study showing why the requested treatment is relevant for patients like you with T1D].

For all of the reasons outlined above, I am requesting that my plan [name] cover [medication/device/service] for [me or my loved one].

Sincerely,
[Name]