

[Current Date]

Attn: Director of Claims  
[Insurance Policy Carrier]  
[Insurance Policy Address]

Re: Patient: [Patient Name]  
Policy: [Insurance Policy Number]  
Insured: [Responsible Party Name]  
Treatment Dates: [Admission Date] - [Discharge Date]  
Amount: [Total Charges]

Dear Director of Claims,

It is our understanding that this claim was denied pursuant to your decision that the care was not medically necessary.

The explanation of benefits did not give adequate information to establish the accuracy of this decision. Therefore, please provide the following information to support the denial of benefits for 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 which would be necessary in order to approve the treatment.

Further, we would appreciate copies of any expert medical opinions which have been secured by your company in regards to treatment of this nature and its efficacy so that the treating therapist may respond to its applicability to this patient's condition.

Thank you for your assistance.

Sincerely,

Patient Accounts Manager