[~Current Date~]

Attn: Director of Claims
[~Insurance Policy #1 Carrier~]
[~Insurance Policy #1 Address~]

Re: Patient: [~Patient Name~]
Policy: [~Insurance Policy #1 Number~]
Insured: [~Responsible Party Name~]
Treatment Dates: [~Admission Date~] - [~Discharge Date~]
Amount: [~Total Charges~]

Dear Director of Claims,

According to our records, your company denied this claim due to your determination that the prescribed treatment was not medically necessary.

It is our position that this treatment was medically necessary. Therefore, we wish to appeal denied benefits pursuant to Title 29 of the United States Code of Federal Regulations, Section 2560.503-1(g), "Review Procedure." These regulations govern employer-sponsored health plans (ERISA) and requires the following regarding appeal review:

(1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:
(i) Request a review upon written application to the plan;
(ii) Review pertinent documents;and
(iii) Submit issues and comments in writing.
(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the ``appropriate named fiduciary" for purposes of this section. In all other cases, the ``appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.
(3) A plan may establish a limited period within which a claimant must file any request for review of a denied claim. Such time limits must be reasonable and related to the nature of the benefit which is the subject of the claim and to other attendant circumstances. In no event may such a period expire less than 60 days after receipt by the claimant of written notification of denial of a claim.

We request immediate reconsideration of the above referenced claim in accordance with the above referenced mandate. If the denial is upheld, please provide all pertinent documents related to the grievance for our review. We appreciate your prompt response.

Sincerely,

Claims Analyst