

[~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,

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 medical professional who reviewed the treatment records. This information is necessary to determine if the medical professional maintains a medical license for this state. 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.

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 physician/physical therapist may respond to its applicability to this patient's condition.

Thank you for your assistance.

Sincerely,

Claims Analyst