Sample Appeal Letter

This sample letter is intended to provide an example of the types of information that may be included when responding to a request from a patient's insurance company to provide an appeal letter for a Mitsubishi Tanabe Pharma America, Inc. medication you seek to prescribe. Use of the information in this letter does not guarantee that the health plan will provide reimbursement for the medication. Use of this sample letter is completely voluntary by the healthcare provider and/or patient and is not intended to be a substitute for, or to influence, the independent medical judgment of the physician.

Helpful tips

- You may consider including an appeal letter (like the example on page 2 of this document) if coverage is denied because your patient's condition did not meet the plan's criteria for treatment with the medication
- An appeal letter should be signed by **both** the physician and the patient
- Be sure to include an appropriate *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) that matches your patient's diagnosis
- When you download this document, **make certain to delete page 1 of this document**

Example Checklist Summary

- ❑ Appeal form recommended by health plan
- ❑ Example chart notes
  - Date of initial diagnosis
  - Reason for the medication or treatment
  - Recommended treatment plan
  - Pertinent laboratory, diagnostic, and imaging tests and results
  - Patient's clinical response
  - Brief description of the patient's recent symptoms and conditions
  - Previous therapies the patient has undergone for the symptoms associated with their condition, and the patient's response to these therapies
- ❑ A copy of the Prescribing Information for the medication

Sample Format for an Appeal Letter

[Insert Your Practice/Physician Letterhead]

Attn: [Insert Medical Director Name]

RE: [Insert Patient Name]
[Insert Name of Insurance Company]
[Insert Address]
[Insert City, State ZIP Code]

DOB: [Insert Patient's Date of Birth]
Policy Number: [Insert Patient Policy Number]
Claim Number: [Insert Patient Claim Number]

[Date]

Dear [Insert Contact Name]:

This letter serves as the [Select one: first/second] appeal for approval of treatment with [medication] for my patient, [Insert Patient Name]. Based on your letter of denial dated [MM/DD/YYYY], coverage was denied because my patient's condition did not meet the plan's criteria, specifically [Insert the reason(s) provided in the denial letter].

[Insert Patient Name] has been under my care for [Insert Diagnosis] [Insert ICD-10-CM Code] since [Insert Date]. Treatment with [medication] is medically appropriate and necessary for [Insert Patient Name] and should be covered and reimbursed. Below, this letter outlines [Insert Patient Name]'s medical history, prognosis, and treatment rationale.

[NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition. You may want to include:]

Summary of Patient's Medical History:

- [Patient's diagnosis, date of diagnosis, condition, and history]
- [Previous therapies used for treating the symptoms associated with the condition]
- [Patient's response to these therapies]
- [Brief description of the patient's recent symptoms and conditions]
- [Summary of your professional opinion of the patient's prognosis and why medication is medically necessary for this patient]

In order for me to provide appropriate care for my patient, it is important that [Insert Plan Name] provide adequate coverage for this treatment.

Please call my office at [Insert primary phone number] if I can be of further assistance or you require additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

[Insert Physician Name and Participating Provider Number]
[Insert Patient/Legal Representative Signature, if required]

Enclosure:
[Insert a PDF of the Prescribing Information for medication]

For US audiences only.
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