Considerations for Composing an APPEAL LETTER

Prior Authorizations (PA) or coverage requests may be denied for various reasons; when they are, an Appeal may be submitted. Including a formal Appeal Letter which outlines the clinical rationale for prescribing the medication can help facilitate the health insurance plan's review process.

HELPFUL TIPS

Understand the reason for the denial
- Common reasons include errors, missing information, or failure to demonstrate medical necessity
  - If the denial was due to a documentation error, contact the payor directly to adjust or correct the form without having to proceed with an Appeal Letter

Follow the payor-specific appeals process and work within the timeline

Compose an easy-to-follow letter. Refer to the example provided in this guide
- Establish the reason for the Appeal Letter
- Describe the patient’s diagnosis and treatment plan
- Include information on the treatment up to this point, course of care, why the treatment/medication is necessary, and how you expect it to help the patient. This may include items such as the patient’s pertinent medical history, recent labs, etc.

Be detailed yet concise
Recommended information for an Appeal Letter includes:

1. Patient information:
   - Full Name
   - Date of Birth
   - Subscriber Insurance Group Number
   - Subscriber Case ID Number
   - Subscriber Insurance ID Number

2. An introduction stating the purpose of the Appeal Letter (i.e., the reason for the denial) that indicates you are familiar with the health insurance plan’s policy.

3. A summary of the patient’s diagnosis and the indication for the medicine being prescribed.
   Be sure to include: The diagnosis code(s) (ICD-10-CM), the severity of the patient’s condition, prior treatment(s) including the duration of each and the patient’s response to each treatment.

4. An explanation of why other treatments may not be appropriate for the patient.

5. A summary of your recommendation.

6. Additional enclosures as needed, which may include:
   - Prescribing Information
   - Relevant peer-reviewed articles
   - Copy of denial letter
   - Clinical notes/medical records
   - Clinical practice guidelines
   - Diagnostic test results

ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification.
[PHYSICIAN LETTERHEAD]

[Date]

[Payor Name]

ATTN: [Contact Title/Medical Director]
[Contact Name (if available)]
[Payor Address]
[City, State, Zip]

Re: Appeal for Denial of [Product Name]

Patient: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Subscriber ID Number: [Insurance ID Number]
Subscriber Group Number: [Insurance Group Number]
Case ID Number: [Case ID Number]

Dear [Contact Name or Medical Director]:

I am writing to request that you reconsider your denial of coverage for [Product Name] [dosage], which I have prescribed for my patient [Patient First Name] [Patient Last Name], [Product Name] is FDA approved for the treatment of [list indication] in patients with [Diagnosis].

Your reason[s] for the denial is/are [list reasons provided]. Listed below are the patient’s diagnosis, labs and medical history, which confirm the medical necessity and appropriate treatment plan with [Product Name].

Patient’s Diagnosis, Labs and Medical History
[Patient First Name] [Patient Last Name] is diagnosed with [Diagnosis] (Diagnosis Code [Insert Diagnosis Code]). [His/Her] labs are as follows:
[List relevant labs]

Patient [is/is not] currently on dialysis and has stage [Insert stage] chronic kidney disease. [He/She] has been prescribed [Product Name] (Insert dosage and directions for use) to [Insert reason for prescribing].

Patient has already tried and failed [insert relevant medication history] due to [Insert reason]. Patient is not a candidate for [insert relevant medications] due to [insert risks/prior history].

Summary
I believe [Product Name] is appropriate and medically necessary for this patient and appreciate your time in reviewing and reversing your previous decision to deny coverage. If you have further questions, please do not hesitate to contact me at [Contact Phone Number] or [Contact E-mail Address].

Sincerely,

[Signature of Physician]
[Name and Credentials]

Enclosures

This letter template is being provided for your reference only. Use of this template does not guarantee coverage or reimbursement for any particular drug. You are responsible for ensuring that all information submitted to third-party payors is complete and accurate. You should modify this template as necessary to reflect your patient’s medical condition. It is not intended to substitute for your independent medical judgment.