<Date>
<Payer Name><Payer Address>
<Payer City, State and Zip>

Re: <Patient's Name>
<Type of Coverage>
<Group Number/Policy Number>

Date of Service	HCPS Code	Claim Number	Billed Amount	Denial Date
Enter Text Here	Enter Text Here	Enter Text Here	Enter Text Here	Enter Text Here

To Whom It May Concern:

I am requesting a First-Level Appeal/Second-Level Appeal by a <Oncology/Rheumatology/KidneyTransplant> Medical Advisor of the denial of the above-referenced line item(s). It is my understanding based on your Letter of Denial dated <Insert Date> that <Drug Name> has been denied because: <Quote the specific reason for the denial stated in denial letter>

The case in question involves a patient with <ICD-10 Code> <Diagnosis Name> using a treatment regimen of <Drug Name>. The enclosed documentation relates to the use of <Drug Name> for <ICD-10 Code> <Diagnosis>.

The following items are enclosed:

- Medical literature regarding the use of <Drug Name> for <ICD-10 Code> <Diagnosis Name>
- Relevant clinical documentation such as: history and physical, progress notes, treatment history, Letter of Medical Necessity (LOMN)
- Copies of the EOBs
- Compendia listings and/or coverage policies if applicable

In view of the above information found in the appeal packet attached, I believe all claims should be covered and paid.

Sincerely,

<Provider Signature>
<Provider Name>