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

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

Reference Number	Therapy	Submission Date	Denial Date
Enter Text Here	Enter Text Here	Enter Text Here	Enter Text Here

To Whom It May Concern:

I am requesting a First-Level/Second-Level Appeal by a <Oncology/Rheumatology/Kidney Transplant> Medical Advisor for the prior authorization 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>.

As you know, <Patient> was diagnosed with <Disease> on <Date>. Currently Dr. <Name> believes that <Patient> will significantly benefit from <Procedure/Drug Name(s)>. Please see the enclosed letter from Dr. <Name> that discusses <Patient's> medical history in more detail.

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)
- Applicable coverage policies

In view of the above information found in the appeal packet attached, I believe the request should be covered.

Sincerely,

<Provider Signature>
<Provider Name>