Authorization Appeal

medical director or the chairman of
utilization review committee
insurance name
insurance address 1
insurance address 2
city, state, zip

Patient:
Insured:
Id no:
Service date:
Claim(s) no(s):
Re:

Dear :

On *(date),* I recommended *(test/procedure)* for *(patient)* to be performed on *(date)*. On *(date)*, your plan issued a denial for authorization of payment. However to enable me to continue to provide my patient, *(state name)* with quality care, I request that you reconsider your determination due to the following factors:

(list with bullets points)

It is my medical opinion, that a *(test/procedure)* is very important in the overall care for this patient. *Patient Name* has been diagnosed with *(diagnosis)*. The *(test or procedure)* is necessary to *(state reason)*.

I am forwarding a copy of this letter to *(patient)* and requesting *(patient)* to obtain the *(test/procedure)* despite your refusal to authorize for reasons set forth in this letter and in prior discussions.

Sincerely,

Physician name

Cc: patient