

Appeal Letter Template

Use of this document does not guarantee coverage for your patient. This document is intended to provide you with an example of the type of information that is typically required when providing an appeal letter. The contents of your letter must be based on your medical judgement and align with the patient's medical records. Content below contained in brackets is intended for guidance only and should be replaced with appropriate patient-specific information before sending your customized letter to your patient's insurance provider.

[Payer name]

[Payer address]

[Payer fax, if needed]

Re: Appeal for denial of BEQALZI™ (sonrotoclax)

Member name: [Name]

Member date of birth: [MM/DD/YYYY]

Subscriber number: [Subscriber number]

Group number: [Group number]

Dear [Medical Reviewer name],

This letter is to request a reconsideration of the denial for BEQALZI prescribed for my patient, [Patient name]. The denial reason provided is [State reason provided from the payer]. Please review the clinical details confirming the medical necessity for the treatment.

Patient's diagnosis and medical history:

[Provide brief clinical description of patient, rationale for using BEQALZI, and treatment history. List all current and past therapies.]

Treatment plan:

[Explain why this drug is medically necessary for this patient.]

In summary, I believe that BEQALZI is an appropriate therapy for [Patient name]. If you have further questions, don't hesitate to contact me at [Phone or email].

Thank you for your consideration.

Sincerely,

[Physician signature]

[Physician name]

Attachments for review: [Provide clinical notes, diagnostic tests, and any clinical information relevant to the decision to treat the patient.]