**Letter to File an Appeal**

[Date]

[To:] Plan Fiduciary

[Re:] Patient name/address/telephone number/date of birth
Social Security (or health plan identification) and Group Policy numbers

Sent via US Postal Service - Certified Mail

This is to notify you I am acting as the authorized representative for the above indicated patient and am submitting this appeal for the reason(s) indicated below. Enclosed please find a copy of the patient signed Authorization Form, authorizing me to act as the patient's representative in this appeal.

This request follows U.S. Department of Labor guidelines that indicate:

> *"A plan's claims procedures may not preclude an authorized representative (including a health care provider) from acting on behalf of a Claimant and further provides that a plan may establish reasonable procedures for verifying that an individual has been authorized to act on behalf of a Claimant."*

**This appeal is filed for the following reasons:**

- ◻ Denial of a claim(s) for date(s) of service: ________________________________
- ◻ Denial of the following benefits: ________________________________________

  on these date(s): _______________________________

**Documentation enclosed includes the following:**

- ◻ Relevant explanation(s): ______________________________________________
  - ◻ Additional documentation is attached.
- ◻ Clarifying documentation (related to the initial claim denial or denial of benefits):
  - ◻ History of denial (attached)
  - ◻ Patient health records (attached)
  - ◻ Explanation of Benefits (attached)

**Requested resolution:**

- ◻ Reimbursement of previously denied claim(s) for date(s) of service: _______________
- ◻ Approval for coverage of these previously denied benefits: ______________________

While I do not expect this to be the case, please note U.S. Department of Labor regulations indicate if a plan fails to provide a process that meets the regulatory minimum standards, the enrollee/beneficiary is deemed to have exhausted the available administrative remedies and is free to pursue a claim in U.S. Federal Court.

Should you have any questions, feel free to contact me. Thank you for your review and action on this appeal.

Sincerely,

[treating provider]
[treating provider address, telephone number, and license number]

cc: [insert patient name address]

Attachments [insert copies of the Authorization Form and support documentation.]