

# Sample Appeal Letter

Date

**[Medical Director]**  
**[Insurance Company]**  
**[Address 1]**  
**[Address 2]**  
**[City, State, Zip]**

RE: Patient Name:  
Policy Number:  
Claim Number:

Dear:

I am writing to formally request re-consideration of a denied claim, # **[claim number]**, for services provided to **[patient name]** who is insured under your plan, policy # **[policy number]**. In brief, treatment of **[patient name]** with Boniva<sup>®</sup> (ibandronate sodium) Injection was medically appropriate and necessary and should be a covered and reimbursed service. Below, this letter outlines **[patient name]**'s medical history, prognosis and treatment rationale.

## **Summary of Patient's History**

**[outline patient history, symptoms, diagnosis, previous therapies, prognosis]**

**[Provide rationale for treatment with Boniva Injection]**

Given the patient's history and condition, it is my professional opinion that treatment with Boniva Injection was warranted, appropriate and medically necessary.

Please call my office at **[telephone number]** if I can provide you with any additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

**[Physician name]**

**[Participating provider number]**