Appeals & Grievance Department
[Medicare Administrative Contractor Name**]**
[Address]
[City, State and ZIP Code]

[Date]

Re:
[Last name, First name]
Medicare Number:

Appeal of Denial of Coverage for [denied service or treatment] **on date of service** [month, date and year of service or treatment]

Dear Appeal Reviewer:

I am requesting an initial appeal for the following adverse decision which is attached [*include copy of denial letter*].

The initial request was denied for the stated reason [*insert reason for the denial*].

I am submitting attached information from my provider which will help you understand why this is the best and most appropriate treatment for my condition [*include supporting information from your provider*].

The ICD-10 and CPT codes are covered by Medicare according to the applicable NCD and/or LCD. This is a standard treatment for this condition and is not being provided through a clinical trial.

[*List and attach any failed treatment and/or why other alternative treatments are not appropriate for your condition according to your treating physician)*]

ATTACHMENTS

[Printed name]