[Date]
[Contact Name]
[Insurance Company]
[Insurance Company Address]
[City, State ZIP Code]
[Fax Number]

ATTENTION: **2nd APPEAL**

Re:
[Your last name, first name]
[Insurance policy Number]
[Insurance group Number]
[Date of Birth]
[Claim Number (*found on Explanation of Benefits/EOB*)]
[***Date of first appeal denial***]

I am writing to request a second review of a denial for coverage of [denied service] for date of service [date of care].

[Insurance company] has denied this claim for the following reasons:

- [Insert reasons]

The medical history and course of treatment are as follows:

- [Insert ***new supporting information*** from the provider ***responding to the issues discussed in the insurance company's second denial*** including history, test results, previous and current treatment regimens and their outcomes]

I respectfully request that you review the ***submitted additional documentation*** and consider overturning your coverage decision.
I look forward to your reconsideration.
If I can provide any additional information, please contact me.

Attachments
[On separate paper, include relevant information, for example: Explanation of benefits (EOB); supporting clinical documentation (progress notes describing treatment history and outcomes); prior authorization records (if applicable)]

[Your printed name]