[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
Kaiser Permanente
[Claims Department Address]
[City, State, Zip Code]
Subject: Prescription Appeal for [Medication Name]
Dear Kaiser Permanente Claims Department,
I am writing to formally appeal the denial of coverage for my prescription medication, [Medication Name], which was prescribed by my doctor, [Doctor's Name], on [Date of Prescription]. My member ID is [Your Member ID].
The denial was communicated to me on [Date of Denial], with the reference number [Denial Reference Number]. I believe this denial was made in error because [briefly explain reason for appeal, including any relevant medical information or documentation].
Attached to this letter are supporting documents, including [list any enclosed documents, such as medical records, letters from your doctor, etc.], which further illustrate the necessity of this medication for my health condition.
I kindly request that you reconsider this coverage decision in light of the information provided. Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Member ID]