[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
Subject: Appeal for Medical Reimbursement Claim [Claim Number]
Dear [Claims Adjuster's Name or "To Whom It May Concern"],
I am writing to formally appeal the denial of my medical reimbursement claim [Claim Number], dated [Date of Denial]. The claim was denied on the grounds of [Reason for Denial].
I respectfully request that you review my appeal in light of the following information:
1. **Patient Information**:
 - Patient Name: [Your Name]
 - Policy Number: [Your Policy Number]
 - Date of Service: [Date of Service]
 - Provider Name: [Healthcare Provider Name]
2. **Details of Services Provided**:
 [Brief overview of the medical services received, including any relevant dates and diagnosis.]
3. **Justification for Reimbursement**:
 [Explain why the services were necessary and should be covered under your policy, including references to relevant policy language if applicable.]
4. **Supporting Documents**:
 - [List of attached documents: medical records, bills, EOBs, letters from providers, etc.]
I believe the denial was made in error and request that you reconsider the claim based on the provided evidence. Please let me know if you require any additional information to facilitate your review.
Thank you for your attention to this matter. I look forward to your prompt response.
Sincerely,
[Your Name]
[Your Signature (if sending a hard copy)]