[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]
Subject: Appeal for RX Replacement Denial
Policy Number: [Your Policy Number]
Claim Number: [Your Claim Number]
Dear [Insurance Company Representative's Name],
I am writing to formally appeal the denial of coverage for the prescription medication [Medication Name] that was replaced on [Date]. My doctor, [Doctor's Name], prescribed this medication for the treatment of [Condition/Diagnosis].
The denial letter I received dated [Denial Letter Date] stated that [Reason for Denial]. However, I believe this decision warrants reconsideration based on the following points:
1. **Medical Necessity**: [Provide details and supporting evidence from your healthcare provider regarding the necessity of the medication.]
2. **Previous Authorization**: [Mention if there was any prior approval or authorization related to the medication.]
3. **Alternative Medications**: [Discuss the ineffectiveness or adverse effects of alternative medications.]
Attached are the relevant documents, including my prescription, medical records, and any other supporting information to aid in the review process.
I respectfully request that you reconsider my claim for the replacement of [Medication Name] and approve coverage as warranted by my medical condition. Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Signature (if sending a hard copy)]
[Attachments: List of documents enclosed]