

[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 Denied Workers' Compensation Claim - [Claim Number]

Dear [Claims Adjuster's Name],

I am writing to formally appeal the denial of my workers' compensation claim, reference number [Claim Number], which was denied on [Date of Denial] due to [briefly state the reason for denial].

I respectfully request a reevaluation of my case based on the following information:

1. **\*\*Incident Details\*\***: [Provide a brief description of the incident, including date and location.]
2. **\*\*Medical Evidence\*\***: [Include any supporting medical documentation, such as doctor's reports or treatment records, that validate your claim.]
3. **\*\*Witness Statements\*\***: [If applicable, mention any statements from witnesses supporting your account of the incident.]
4. **\*\*Insurance Policy Details\*\***: [Briefly refer to your coverage details that support your claim.]

In light of this information, I kindly urge you to review my case and reconsider the initial decision. I am committed to providing any additional documentation or information required to facilitate this process.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]