[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 Denial of Coverage for Xtandi
Dear [Insurance Company Representative's Name],

I am writing to formally appeal the denial of coverage for the medication Xtandi (enzalutamide) for my treatment. My claim, [Claim Number], was denied on [Date of Denial] due to [briefly explain reason for denial].
I would like to provide additional information to support my case:
1. **Medical Necessity**: [Explain your diagnosis and why Xtandi is medically necessary for your treatment. Include physician's recommendations and any relevant medical history.]
2. **Supporting Documentation**: [List attached documents such as letters from your healthcare provider, medical records, and clinical studies that support the use of Xtandi for your condition.]
3. **Policy Coverage**: [Cite specific sections of your insurance policy that support the coverage of Xtandi or similar treatments.]
I kindly request that you reevaluate my case based on this additional information. Xtandi is critical for my health, and I hope the review will lead to a favorable resolution.
Thank you for your attention to this matter. I look forward to hearing from you soon.
Sincerely,
[Your Name]
[Policy Number]