[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, ZIP Code]
Re: Coverage Approval Request for Xtandi
Dear [Insurance Company Representative's Name],
I am writing to request coverage approval for the medication Xtandi (enzalutamide) for my [relationship to patient, e.g., father, mother, patient self], [Patient's Name], who has been diagnosed with [specific medical condition, e.g., metastatic castration-resistant prostate cancer].
Patient Information:
- Name: [Patient's Name]
- Date of Birth: [Patient's DOB]
- Insurance ID: [Patient's Insurance ID]
Medical Necessity:
[Provide a brief summary of the patient's medical history, prior treatments, and current diagnosis. Include why Xtandi is the appropriate treatment option and references to supporting medical guidelines or clinical trials, if applicable.]
Prescribing Physician:
- Name: [Physician's Name]
- Practice Name: [Physician's Practice Name]
- Contact Information: [Physician's Phone Number and Email]
I have attached the supporting documents including [list any attached documents, such as the prescription, medical records, and letters of medical necessity].
Thank you for your attention to this matter. I look forward to your prompt response regarding the coverage approval for Xtandi.
Sincerely,
[Your Name]
[Your Title, if applicable]
[Your Relationship to Patient]
Attachments:
1. Prescription for Xtandi
2. Medical Records
3. Letter of Medical Necessity