[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department Address]
[City, State, ZIP Code]
Re: Appeal of Workers' Compensation Claim [Claim Number]
Dear [Claims Adjuster's Name or "Claims Department"],
I am writing to formally appeal the decision made by [Insurance Company Name] regarding my workers' compensation claim (Claim Number: [Claim Number]), which was denied on [Date of Denial].
I believe the denial was made in error because [briefly explain the reason for denial and your justification]. In light of the following information, I respectfully request a reevaluation of my claim:
1. **Injury Details**: [Provide a brief description of your injury and how it occurred.]
2. **Medical Documentation**: [Reference any attached documents, such as medical records or opinions from healthcare providers that support your claim.]
3. **Employment Details**: [Explain your employment status and how the injury impacts your ability to work.]
Enclosed are copies of all relevant documents, including [list of documents, e.g., medical records, accident reports, etc.], that support my position.
I kindly request that you review my appeal and the enclosed evidence thoroughly. I look forward to your prompt response and hope for a favorable resolution to my claim. Please feel free to contact me at [phone number] or [email address] should you need any further information or clarification.
Thank you for your attention to this matter.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Job Title (if applicable)]