

"Sample Letter of Appeal"

Date

Insurer Name

Insurer Address

City, State, Zip Code

Attention: Claims Department

Re: Patient's Name
Policy Number
Treatment Date (Include all date(s) of service)
Amount (Give total dollar amount of charges filed)

Dear Director of Claims,

The above referenced claim was denied on _____ despite the fact that our office verified benefits and obtained prior authorization of care from your plan on _____.

Mr./Ms. _____ has been treated for _____ with the following treatment modalities:

Apligraf[®] has been shown to heal more wounds faster in patients with venous stasis and diabetic foot ulcers. To date Mr./Ms. _____ wound(s) has gone from _____

It is my belief that Mr./Ms. _____ has benefited from Apligraf therapy, and therefore the services rendered should be covered under his/her plan. Please feel free to contact me if you require additional information to reconsider your coverage decision.

Sincerely,