Letter of Appeal

Date:

To: Insurer Name
Insurer Address
City / State / Zip Code
ATTN: Claims Department

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

Dear Director of Claims,

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

Mr./Mrs. Patient Last Name has been treated for Patient's Diagnosis with the following treatment modalities:

Provide all treatment modalities used, dates of service, and outcomes

Apligraf® has been shown to heal more wounds faster than conventional therapy alone in patients with venous stasis and diabetic foot ulcers. To date, Mr./Mrs. Patient Last Name 's wound(s) has gone from Provide wound dimensions prior to treatment, and current dimensions.

It is my belief that Mr./Mrs. Patient Last Name 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,

Physician's Name