

# Sample Letter of Medical Benefit Coverage Request

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**IMPORTANT: When using this template, please be sure to include both the brand name and generic name of the product in the first paragraph.**

[Insurance Company]  
[Address]  
[City, State, Zip]

Re: [Patient Name]  
[Policy #]  
[DOB]  
[Address]  
[City, State, Zip]

To Whom It May Concern:

I am writing on behalf of my patient, [Patient Name, ID and Group Number] to request a determination of coverage approval of [Product brand name (generic name)] associated with [ICD 10 Code] under medical benefits coverage. The patient has been notified that there is no coverage for the product.

**Patient's History, Past Treatments and Drugs Utilized (1500-character limit):**

[Include information outlining when the patient was diagnosed and severity of symptoms. Provide patient response to past treatments].

**Treatment Rationale (1500-character limit):**

[Provide information on patient response to past treatments and anticipated prognosis and rationale for the currently prescribed product].

**Supporting Study Data (1500-character limit):**

[Include references to published medical study data evaluating the use of the currently prescribed product. Remember to include the FDA approved indications and usage].

The ordering physician is [Physician Name, NPI #]. The coverage determination decision may be faxed to [Fax #] or mailed to [Physician Business Office Address]. Please also send a copy of coverage determination decision to the patient.

Sincerely,

[Physician Name and Signature]  
[Phone #]

**Enclosure: [Pharmacy coverage determination denial]**