Sample Letter of Medical Benefit Coverage Request

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]