

*[Your Name]*

*[Your Address] [City, State ZIP Code]*

*[Your Phone Number] [Your Email Address]*

*[Date]*

*[Insurance Company Name]*

*[Address] [City, State ZIP Code]*

Dear Sir/Madam,

I am writing to request reconsideration of a denied medical claim for [name of service or treatment]. I received a letter on [date] stating that my claim for [name of service or treatment] has been denied due to [reason for denial]. I would like to request that you reconsider this decision and approve my claim.

I have consulted with my healthcare provider, and they have confirmed that [provide reasons why your healthcare provider believes the treatment is medically necessary and should be covered by insurance].

I have attached copies of all relevant documents, including medical records, bills, and other supporting documentation. I would be grateful if you could review my case and reconsider your decision.

Thank you for your time and attention to this matter. I look forward to your prompt response.

Sincerely,

*[Your Name]*