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Medical Necessity Appeal Letter

Appeal a claim denied based on lack of medical necessity (CO-50 / CO-57)

PROVIDER INFORMATION

Date:	*[Today's Date]*
Practice Name:	*[Your Practice Name]*
Address:	*[Street, City, State, ZIP]*
Phone:	*[Phone Number]*
NPI:	*[NPI Number]*
Tax ID:	*[Tax ID / EIN]*

PAYER / INSURANCE COMPANY

Insurance Company:	*[Insurance Company Name]*
Appeals Department:	*[Department Name or Address]*
Address:	*[Street, City, State, ZIP]*
Fax:	*[Fax Number]*

CLAIM REFERENCE

RE: APPEAL OF CLAIM DENIAL

Patient Name: *[Patient Full Name]*
Date of Birth: *[MM/DD/YYYY]*
Member / Policy ID: *[Member ID]*
Claim Number: *[Claim Number]*
Date of Service: *[MM/DD/YYYY]*
CPT Code(s): *[CPT Code(s)]*
Diagnosis (ICD-10): *[ICD-10 Code(s)]*
Denial Reason: CO-50 / CO-57 — Medical Necessity

LETTER OF APPEAL

Dear [Insurance Company] Medical Review Department,

We are writing to appeal the denial of the above-referenced claim. The service was denied as not medically necessary (CO-50 / CO-57). We respectfully disagree with this determination and submit the following clinical justification for reconsideration.

CLINICAL JUSTIFICATION: [Describe the patient's presenting condition, relevant history, and why the service was clinically indicated. Include relevant symptoms, prior treatment attempts, and how this service aligns with accepted clinical guidelines.]

Example: The patient presented with [diagnosis/symptoms]. Prior conservative treatments including [list prior treatments] were attempted and failed. The service provided — [CPT description] — was medically necessary to [describe clinical goal: diagnose, treat, prevent deterioration, etc.] in accordance with [reference clinical guideline, LCD, or NCD if applicable].

APPLICABLE COVERAGE CRITERIA: This service meets the medical necessity criteria outlined in [payer's] coverage policy [policy number if known] / Local Coverage Determination (LCD) [L-number if applicable] for [diagnosis / condition]. Relevant criteria met include:

[List each criterion and how the patient meets it]

We request that [Insurance Company] reverse this denial and process the claim for reimbursement. The treating provider is available to discuss the clinical rationale if a peer-to-peer review would be helpful. Please contact [provider name] at [phone number] to schedule.

ENCLOSURES

- Clinical notes / progress notes from the date of service
- Relevant prior treatment records
- Applicable clinical guideline, LCD, or NCD reference
- Any prior authorization documentation (if obtained)

Sincerely,

Provider Signature: _____

Printed Name: *[Provider Name]*

Title: *[Title / Credentials]*

Date: *[Date]*

Enclosures listed above. Keep a copy of this letter and all supporting documentation for your records.