SAMPLE LETTER OF DENIAL APPEAL

[Date]
[Payer Name]
[Payer Address]
Attn: **[Appeals Department]**

Re: **[Patient Name]**
[Policy Number]
[Claim Number (if applicable)]
[Date(s) of Service]

Dear **[Medical Director]**:

I am writing to request an appeal of the RETACRIT™ (epoetin alfa-epbx) injection **[strength]** claim denial for **[Patient Name]**. Please see the enclosed documentation that supports the use of this therapy, which was approved by the FDA on May 15, 2018.

The reason for the denial, which was explained on **[explanation of payment or remittance advice]**, was **[reason(s) for denial]**. I disagree with this decision and request that this claim be approved.

[Patient Name] was diagnosed with **[indication]** on **[insert date]. [He/She]** received treatment with RETACRIT on **[date]**. In my clinical judgment, treatment with RETACRIT was medically justified.

[Describe patient's disease state and provide clinical justification for RETACRIT treatment that may include:]

- **[Diagnostic test results]**
- **[Previous inadequate response, contraindications, or intolerance to other treatments]**

My patient, **[Patient Name]**, has responded to RETACRIT therapy, and I believe treatment was medically justified. I request that you reconsider this claim and approve this therapy.

Please call my office at **[Telephone Number]** if you require any additional information or documentation. I look forward to your timely response.

Sincerely,

[Physician Name]
[Address]
[Telephone Number]

Enclosures **[to be determined by physician]**

[This document is provided as a sample template that may be used to appeal a payer coverage decision. The physician is responsible for the content of the letter that is customized to include information concerning an individual patient.]

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