

Date:

Date of birth:

To whom it may concern:

My name is _____, and I am a _____ writing on
behalf of my patient, _____, to request coverage for
has been under my care for _____ months/ _____ years for the treatment of _____.

We understand that the reason for your denial is _____.

However, we believe that _____ is the appropriate treatment for my patient.
In support of our recommendation for _____ treatment, we have provided an overview of
my patient's relevant clinical history below.

The patient's _____ are enclosed, which offer additional
support for the formulary exception request for _____ .Please consider coverage of
_____ for my patient.

Please feel free to contact me, _____, at office number _____
or _____ at _____ for any additional information you may
require. We look forward to receiving your timely response and approval of this claim.

Sincerely,

Phone:

Fax: