SAMPLE:
This letter is only intended as a TEMPLATE Letter of Appeal.
INSTRUCTIONS: MUST BE ON HCP'S LETTERHEAD AND MUST BE COMPLETED AND SUBMITTED BY THE HCP.

[Provider Letterhead]

[Date]

[Name of insurance company]

[Insurance company address]

[Contact Name]

[Contact Title]

Re: Appeal of Denied Coverage for [CAR T Product Name]

Member Name	[Patient name]
Date of Birth	[Patient date of birth]
Member ID Number	[Patient member ID number]
Member Group/Policy Number	[Patient member group/policy number]
Denied PA/Claim Reference Number	[Denied PA/Claim Reference Number]

[Dear Name:/To whom it may concern:]

I am writing to request an expedited appeal, to reconsider your denial of coverage for [CAR T Product Name] for [patient's diagnosis].

According to your letter dated [Denial Date], coverage was denied due to the following reason(s):

- [Quote denial reason as stated in the denial letter]

Below is a brief description of the patient's diagnosis, medical history, and treatment plan:
[Clearly outline relevant details that document medical necessity]

Primary diagnosis and ICD-10-CM code	[Patient's diagnosis and appropriate code(s)]
Number of prior therapies	[Number of prior therapies]
Description of prior therapies and treatment response	[Description of the patient's prior therapies and their response to each treatment they have received, including dates, inadequate response, and/or adverse events]
Disease characteristics	[Relevant disease-related characteristics, including but not limited to histology and prognostic factors]
Clinical fitness	[Details on the patient's clinical fitness, which may include relevant indicators of organ function and performance status]
Expected prognosis or disease progression if the patient is not treated with [CAR T Product Name]	[Your professional opinion of the patient's likely prognosis or disease progression if they are not treated with (CAR T Product Name)]

ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification.

Based on my clinical judgment and the supporting evidence, as outlined below, I believe that [CAR T Product Name] is warranted, appropriate, and medically necessary for [Patient Name]. Please note that [Treatment Center Name] is designated as an authorized treatment center for [CAR T Product Name].

Enclosed in support of the rationale for treatment are: [insert description of supporting documents, which may include the following examples]

- Consensus statement or treatment guidelines (ie, NCCN)
- Diagnostic test results
- FDA approval letter
- Manufacturer's letter of treatment center authorization
- Medical literature
- Patient treatment history and outcomes
- Peer-reviewed journal articles
- Prescribing Information
- Treatment studies or clinical trials

Thank you in advance for your immediate attention to this request. This treatment is vital to improve and ultimately maintain [his/her] health and life. In the absence of this medically necessary treatment, the patient can succumb to this disease.

Please contact me at [insert office telephone number] or via e-mail at [insert healthcare provider's e-mail address] for any additional information you may require regarding this appeal.

Sincerely,

[Provider Name and Signature]

[NPI Number and Contact Information]

[Treatment Center Name and Address]

Attachments: [List all attachments here. Enclose the denial letter and supporting documentation with this letter]

This letter is provided as an example for your background information and is not intended to be directive, nor should it be construed as clinical or reimbursement advice. Physicians should exercise medical judgment and discretion to appropriately diagnose and characterize the individual patient's medical condition. In addition, healthcare providers are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.

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