[Surgeon Letterhead & Signature]

[DATE]

[NAME OF INSURANCE COMPANY]

[ATTN:]

[FAX #: AND/OR ADDRESS]

**RE: [**PATIENT NAME]

[INSURANCE IDENTIFICATION NUMBER]

[PRIOR AUTH OR REFERENCE #:]

[PRIMARY CPT CODE:]

[PRIMARY DX:]

[CLAIM NUMBER:]

[DATE OF SERVICE/DELIVERY:]

Dear Director of Claims:

I am writing on behalf of my patient, [PATIENT FULL NAME], to request reconsideration of coverage for eXciteOSA. Reimbursement was [DENIED/UNDERPAID] because [STATE REASON GIVEN IN DENIAL LETTER] as indicated in the enclosed letter dated [INSERT DENIAL LETTER DATE]. I will explain why this claim should be reimbursed and the eXciteOSA fully covered for [PATIENT FULL NAME]. I have included information about my patient’s medical history and diagnosis [INSERT ICD-10 CODE], a statement summarizing my treatment rationale, and other documents that support the medical necessity of eXciteOSA in this clinical case.

Since [DATE OF ONSET], [PATIENT FULL NAME] has been under my care for [INSERT ALL PERTINENT DIAGNOSIS RELATED TO PROCEDURE AND APPLICATION OF DEVICE OR PRODUCT]. Below is a summary of the patient’s history:

[TREATMENT HISTORY]

[RESPONSE TO PAST THERAPIES]

[RECENT SYMPTOMS AND CONDITION]

[SUMMARIZE YOUR PROFESSIONAL OPINION OF THE PATIENT’S LIKELY PROGNOSIS OR DISEASE PROGRESSION WITH AND WITHOUT TREATMENT WITH EXCITEOSA]

Based on the patient’s clinical condition and review of the supporting documentation, I am confident that you will agree that eXciteOSA, which is explicitly indicated for this condition, was the appropriate treatment option. In order for me to provide appropriate care for my patient, it is important that [HEALTH PLAN NAME] reimburse our claim and provide adequate coverage for eXciteOSA moving forward. I would appreciate prompt review of this case.

On behalf of [PATIENT FULL NAME], we appreciate your reconsideration. Please call me at [PHONE NUMBER] if I can be of further assistance or if you require additional information. Thank you in advance for your immediate attention to this request.

Sincerely,

[TREATING PHYSICIAN’S SIGNATURE] [PATIENT/LEGALREPRESENTATIVE SIGNATURE]

[TREATING PHYSICIAN’S NAME, MD/DO] [PATIENT/LEGALREPRESENTATIVE NAME]

Enclosures (suggested):

Appeal Form (if provided by Plan)

Chart notes

Test results

Supporting medical studies

Patient narrative