**Letter of Appeal**

**(Practice Letterhead)**

**(Date)**

**(Payer Name)**

**(Payer Representative)**

**(Payer Address)**

**(City, State, ZIP Code)**

**(Payer Fax Number)**

Attention: (Payer Representative)

Attention: (Claims Department)

Re: Coverage of (Product Name) (Generic Name)

Subscriber: (Subscriber’s First and Last Name)

 Patient Name: (Patient’s First and Last Name)

 Policy#/Patient ID: (Policy Number/Patient’s ID)

 Group#: (Group Number)

 Patient Date of Birth: (Patient Date of Birth)

 Treatment Date: (Treatment Date)

Claim #: (Claim Number)

Amount of Claim: (Amount of Claim)

Dear Director of Claims:

I am writing to request a formal review of a denied claim for (**Patient’s Name)**. (Payer Name) has indicated that (Product Name) is not covered for the following reason(s), listed on the attached Explanation of Benefits (EOB):

**(Fill in reason(s) from EOB)**

**(Mr/Mrs/Ms) (Patient’s name)** was prescribed **(Product Name)**. I believe this therapy is an appropriate treatment for my patient. The full Prescribing Information for **(Product Name)** can be accessed at www.rebyota.com.

Summary of Patient History **(you may want to include):**

**(Provide diagnosis, dates of service, outcomes, and rationale for treatment. NOTE: *Physicians should exercise medical judgement and discretion regarding making an appropriate diagnosis and characterization of an individual patient’s medical condition. In addition, physicians are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.*)**

Treatment with **(Product Name)** is a necessary therapy for this patient’s medical condition. I trust that the enclosed information, along with my medical recommendations, will establish the medical necessity for payment of this claim. Please call my office at **(insert telephone number)** if I can provide you with any additional information to approve my request. I look forward to receiving your timely response and approval of this request.

Sincerely,

**(Physician’s Name) (Physician’s Signature)**