

<Date>

<Payer Name>

<Payer Address>

<Payer City, State, Zip code>

Regarding: <Patient First and Last Name>

HIC Number: <HIC #>

Date of Service	Procedure Code	Billed Amount
<Date of Service>	<CPT Code>	\$ <Billed Amount>

To Whom It May Concern:

I am requesting a reconsideration for the above Patient. The following items are enclosed relating to <drug name> treatment for <Patient First and Last Name>, who is being treated for <ICD-10 code> <diagnosis name>.

- Medical literature regarding the use of <drug name> for <ICD-10 code> <diagnosis name> cancer and/or similar cell type diagnosis
- Relevant clinical documentation such as: history and physical, progress notes, treatment history, Letter of Medical Necessity (LOMN)
- Copies of the Explanation of Medicare Benefits (EOMBs)
- Compendia listings if applicable

In view of the above information found in the appeal packet attached, I believe all claims should be covered and paid.

Sincerely,

<Provider Signature>

<Provider Name>