Date

Pre-Service Appeals Department
[Insurance Company Name]
[Address]
[City, State and ZIP Code]

Re: [Patient's Name]
Member ID: [Member ID]

Group Number: [Group number/Policy number]

Reference Number: [from denial letter]

**Subject: URGENT External Appeal of Denial of Coverage for** [Type of Hematopoietic Stem Cell Transplant]

Dear Appeal Reviewer:

I am requesting an URGENT (expedited) external appeal on behalf of [Patient's Name] for the following adverse decision(s) that are included as an attachment to this memorandum [include copies of prior denial letter(s)]. I am requesting an external appeal because this denial involves a medical necessity judgement and the plan’s determination reason states that transplant for this condition is [experimental, investigational or not medically necessary].

The [previous] request for transplant has been denied [on appeal?] [X number of times] for the stated reason [put the specific reason(s) for the denials here]. Please understand that the reason you give for denial is not valid [put reason why it is not valid here] **OR** [I am supplying additional information to help support why this is the most appropriate treatment for this patient]. Waiting for the standard appeal timeframe is not an option for this patient, as it would seriously jeopardize the patient’s life, or ability to regain maximum function for the following reason [insert reason why you can’t wait here – [risk death], [risk spread of disease], [delay has shown to impact outcomes?].

[Patient's Name] is under my care for [name of diagnosis, short description and ICD10 code(s)], which is a [stage of disease?] [life threatening?] condition that causes [insert a description of patient’s S/S]. Without transplant this patient will [what is prognosis without transplant?]

[Indicate here if patient has had and failed prior treatment – describe what the treatment was and the current state of the patient’s disease.]

**OR**

[Indicate here what alternative treatments are and why they are not appropriate for this patient.]

HCT [offers patients with this condition only chance of cure?] **OR** [is the standard of care for this condition?]

Transplant for [X condition] is accepted as the standard of care, and is well supported by respected scientific literature. [Summarize literature findings here.]

Please review the following enclosed medical journal articles:

* **Article #1**
* **Article #2**
* **Article #3**

**OR**

Due to the small number of patients with this disease [deadly? rare?] it is not possible to obtain enough participants for a clinical trial, hence we must rely on small case series to guide treatment. [Summarize published findings.] [Explain why you are taking the approach you are.]

* **Article #1**
* **Article #2**
* **Article #3**

Based on the available medical literature on [Patient's Name’s] condition, I am filing this appeal, specifically requesting that you approve the required [HCT that was denied]. Transplant is the only available treatment for this condition and for this patient. Not approving this transplant leaves this patient with [insert prognosis here].

Sincerely,

[Physician's Name]**, M.D.**

**Enclosures:**

1. Documents referred to in text
2. Completed Appointment of Representative Form