Date

Appeals & Grievance Department   
[Medicare Administrative Contractor Name]  
[Address]  
[City, State and ZIP Code]

Re: [Patient's Name]  
Medicare Number: [Medicare Number]

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

Dear Appeal Reviewer:

I am requesting an initial appeal on behalf of [Patient's Name] for the following adverse decision which is included as an attachment to this memorandum [include copy of denial letter].

The initial request for transplant was denied for the stated reason [put the reason for the denial here] by [insert name of reviewer if on denial letter]. Please understand that the reason you give for denial is not valid [put reason here] **OR** [I am submitting additional information which will help you understand why this is the [best? only?] appropriate treatment for this patient.] The request is for coverage for [enter ICD-10-PCS procedure code and short description here] for [enter ICD-10-CM diagnosis code and short description here]. This diagnosis and procedure code are covered by Medicare according to [NCD 110.8.1 – Stem Cell Transplantation](http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=45&ncdver=5&NCAId=9&IsPopup=y&bc=AAAAAAAAAgAAAA==&). This transplant is a standard treatment for this condition and is NOT being provided through a clinical trial, so no clinical trial number is being provided.

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

[Indicate here if patient has had and failed prior treatment – describe the treatment 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 – explain in detail why transplant is the best treatment choice]. With transplant the likely outcome for [patient name] is [insert likely outcomes and longevity – insert any data you have here].

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 that support this position:

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

**OR**

Due to the small number of patients with this [deadly? rare?] disease 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 **OR** best available] treatment option for this condition and for this patient. Not approving this transplant leaves with patient with [insert prognosis here].

Sincerely,

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

**Enclosures:**

1. Copy of Medicare Summary Notice (MSN)
2. Documents referred to in text
3. Signed Authorization of Representative Form