[Date] [Payer Name] [Payer Address] Attn: [Appeals Department] Re: [Patient Name] [Policy ID/Group Number] [Date of Service]

To whom it may concern:

My name is [name] and I am a [board-certified medical specialty] [NPI] writing on behalf of my patient, [patient name], to request coverage for [product, dosage, and frequency]. [Patient Name] has been under my care for [X months] for the treatment of [disease or symptoms].

I am writing this letter for medical necessity because after working with [Patient name], I believe that [product name] is the best treatment for this patient, and it's important that a formulary exception be made.

[Provide a brief medical history, including diagnosis, allergies, existing comorbidities, and International Classification of Diseases (ICD) code(s)].

[Discuss rationale for using <product name> vs other treatments. Insert your recommendation summary here, including your professional opinion of your patient's likely prognosis or disease progression without treatment.].

[List of pertinent medical records] are enclosed, which offer additional support for the formulary exception request for [product name]. Please consider coverage of [product name] for my patient.

Please contact me at [telephone number] to answer any pending questions. I would be pleased to speak to the medical necessity of [product name] for [patient's name]'s [diagnosis].

Thank you in advance for your attention to this request.

Sincerely,

[Physician Name and signature] [Physician's medical specialty] [Physician's NPI] [Physician's practice name] [Phone #] [Fax #]