Date of letter

Insurance Company Name

Insurance Company Address

Insurance Company City/State/Zip

Re: Request for reconsideration of coverage denial for Out-of-Network services (this may also involve a request for an in-network reimbursement rate)

Your Name

Type of Insurance

Group/Policy Numbers

Subscriber ID Number

Claim Number

Dear [name of representative] or Claims Review Department,

I am writing to you in regard to a claim submitted by [medical provider] for [patient name]. The charges were rendered on [date] and totaled [claim dollar total]. [Health plan] has denied payment for this medical procedure stating that it was out of network and not payable.

OPTION 1 (choose the best paragraph out of these options that applies to your situation)

I went to a facility/physician that was out of network because there was not an in-network facility/ physician who could offer me the appropriate medical treatment needed for my care. Providers who offer high-resolution anoscopy (HRA) for anal high-grade squamous intraepithelial lesion screening and treatment are limited, as reported in the scientific literature.[[1]](#footnote-1) I exhausted a great deal of effort in searching for an in-network facility/physician that could perform a similar service, but was not successful.

OPTION 2

I went to a facility/physician that was out of network because there was not an in-network facility/ physician in my geographical area that could assist me. Providers who offer high-resolution anoscopy (HRA) for anal high-grade squamous intraepithelial lesion screening and treatment are limited, as reported in the scientific literature.1 I exhausted a great deal of effort in searching for an in-network facility/physician that could perform a similar service, but was not successful.

I feel that I should not be penalized for having received treatment which was medically necessary. My medical provider has included a letter of medical necessity stating that the procedure(s) performed were appropriate and medically justified. [*Add only if confirmed with the provider:* Furthermore, this medical provider is willing to accept the in-network negotiated fee for the service performed.]

There is no question that the medical procedures—[list medical procedures that were denied such as anal cytology, HRA with or without biopsy, and/or electrocautery treatment of anal HSIL]—were medically necessary, and I hope you reconsider your denial and pay for all of my outstanding claims associated with this procedure. Thank you for your time and assistance in this matter. My contact information is listed below.

Sincerely,

Your Name

Street Address

E-mail Address

Phone Number

Cell Phone Number

cc: Doctors’ Names and Practice Names

Enclosures:

List each document in your appeals packet

Include a Statement of Medical Necessity from your medical provider

1. Damgacioglu H, Lin YY, Ortiz AP, Wu CF, Shahmoradi Z, Shyu SS, Li R, Nyitray AG, Sigel K, Clifford GM, Jay N, Lopez VC, Barnell GM, Chiao EY, Stier EA, Ortiz-Ortiz KJ, Ramos-Cartagena JM, Sonawane K, Deshmukh AA. State Variation in Squamous Cell Carcinoma of the Anus Incidence and Mortality, and Association With HIV/AIDS and Smoking in the United States. J Clin Oncol. 2023 Feb 20;41(6):1228-1238. doi: 10.1200/JCO.22.01390. Epub 2022 Nov 28. PMID: 36441987; PMCID: PMC9937095. [↑](#footnote-ref-1)