

SAMPLE LETTER OF APPEAL: CLAIM DENIAL

<Date>
<Payer Name>
<Payer Address>

Attn: <Appeals Department>

Re: <Patient Name>
<Policy ID/Group Number>
<Date of Service>
<Disputed Amount>

To Whom It May Concern:

I am writing to request an appeal of the claim denial for <Patient Name> for the administration of FIRAZYR[®] (icatibant injection). FIRAZYR was approved by the U.S. FDA in August 2011 for the treatment of acute attacks of Hereditary Angioedema (HAE) in adults 18 years of age and older.

<Payer Name> has indicated that the reason for the denial, which was explained on the <Explanation of Benefits or Remittance Advice>, was <list reason(s) for denial>. I disagree with this decision and request that this claim denial be reversed.

My patient, who has been diagnosed with HAE, received an injection of FIRAZYR on <Date> for treatment of an acute attack of HAE. In my clinical judgment, treatment with FIRAZYR was medically necessary. <Provide clinical justification for treatment>.

I have enclosed additional documentation that supports treatment with FIRAZYR. I would appreciate your reconsideration of this claim and ask that you consider reversing your decision. If you have any further questions, please feel free to call me at <Physician Telephone #> to discuss.

Thank you in advance for your immediate attention to this request.

Sincerely,

<Physician Name>

<Enclosures: formulary exception form (if required, available on the payer's website), original claim form and subsequent denial/EOB (if relevant), patient medical history, full Prescribing Information, additional supporting documents>