(Date)

(Name of Insurance Company Representative)
(Street Address of Insurance Company)
(City, State, ZIP Code of Insurance Company)

RE: Your Name, Group Number/Policy Number, Case Number/Claim Number

Dear (Name of Insurance Company Representative),

I am writing this letter to appeal the decision of (Name of Insurance Company) to deny coverage for LAP BAND Surgery. The letter of denial dated (insert date) stated that my request for LAP BAND Surgery was denied because "(insert specific quote from denial letter)."

As I believe that the decision was based on incorrect or incomplete information, I wanted to submit the following information that shows why I disagree with the denial and why I believe that LAP BAND Surgery will significantly benefit my health and should be approved.

First, I wanted to review my health history:

- I was diagnosed with (list health condition #1, i.e. morbid obesity) on (insert date). My treatments for this condition include (list all treatments).
- I was diagnosed with (list health condition #2, i.e. type 2 diabetes) on (insert date). My treatments for this condition include (list all treatments).
- I was diagnosed… (repeat for all conditions, including high cholesterol, sleep apnea, arthritis, and all others).

In addition, I have made numerous, serious attempts to lose weight over the years but have been unsuccessful. My previous weight loss attempts include:

- List all weight loss programs (i.e., Weight Watchers, Jenny Craig, NutriSystem) and include receipts
- List all diet plans (i.e., Zone Diet, South Beach Diet, Atkins Diet) and include receipts
- List all exercise attempts (i.e., exercise equipment, gym memberships, personal trainer) and include receipts
- List all weight loss medications and/or medically supervised diet programs, and provide receipts
- List any other weight loss efforts and provide documentation

At this time, my doctor (insert name of doctor) believes that LAP BAND Surgery is medically necessary and is the appropriate treatment for my health conditions. I have enclosed a letter from my doctor supporting this diagnosis and treatment.

I also wanted to provide the following information that supports LAP BAND Surgery as an effective and appropriate treatment for my health conditions.

- Fact #1 (list a specific fact that counters denial statement and supports LAP BAND Surgery as the appropriate treatment for treating your diagnosis, including results of medical studies and information from medical articles)

- Fact #2
- Fact #3 (continue to list all pertinent facts)

Based on the above information and enclosed supportive documentation, I am asking that you reconsider my request and approve coverage for LAP BAND Surgery. My doctor would like to schedule surgery for (insert date). If you need any additional information, please contact me at (telephone number and/or email address).

Thank you for your time and attention to this matter.

Sincerely,

(Your Name)
(Your Street Address)
(Your City, State, ZIP Code)
(Your Telephone Number)
(Your E-mail Address)