Emergency Medical Services Appeal

Director of claims/claims department
insurance name
insurance address 1
insurance address 2
city, state, zip

Patient:
Insured:
Id no:
Service date:
Claim(s) no(s):
Re:

Dear *Director*:

This is to serve as official notification of an request for appeal of the denial received on *(date)* for emergency medical service rendered to *(patient)* on *(date of service)*.

(Patient) was treated on an emergency basis, for *(name condition or diagnosis)*. This condition could not have been predicted therefore *(patient name)* presented with an urgent condition. In addition, its occurrence did not afford *(patient name)* the opportunity to pre-authorize this treatment or to be treated by his physician of record *(state physician name)* for treatment.

I have attached the following medical data which will indicate the appropriateness of my medical judgment to treat *(patient)*.

(list supporting documentation)

After careful reconsideration and review of the enclosed information, it is anticipated that full payment of our
claim(s) will be issued.

Thank you for your prompt attention to this matter.

Sincerely,

Physician

Cc: patient