Date

Pre-Service Appeals Department   
[Insurance Company Name]  
[Address]  
[City, State and ZIP Code]

Re: [Patient's Name]  
Member ID: [Member ID]

Group Number: [Group number/Policy number]

Reference Number: [from denial letter]

**Subject: Appeal of Denial of Coverage for** [Type of Hematopoietic Stem Cell Transplant]

Dear Appeal Reviewer:

I am requesting an external appeal on behalf of [Patient's Name] for the following adverse decision(s) that are included as an attachment to this memorandum [include copies of prior denial letters]. I am requesting an external appeal because this denial involves a medical necessity judgement and your determination reason states that transplant for this condition is [experimental, investigational or not medically necessary]. I would like to request the review be completed by a same or similar specialist to my specialty. Due to the highly specialized nature of this field, an appropriate reviewer is either a stem cell transplanter, or a hematologist/oncologist.

The [previous] requests for transplant have been denied [X number of times] for the stated reason [put the reason(s) for the denials here]. Please understand that the reason you give for denial is not valid [put reason here] **OR** [I am submitting additional information which will help you understand why this is the [best? only?] appropriate treatment for this patient.]

[Patient's Name] is under my care for [name of diagnosis, short description and ICD10 code], which is a [stage of disease?] [life threatening?] condition that causes [insert a description of patient’s S/S]. Without transplant this patient [what is prognosis without transplant?].

[Indicate here if patient has had and failed prior treatment – describe what the treatment was and the current state of the patient’s disease.]

**OR**

[Indicate here what alternative treatments are and why they are not appropriate for this patient.]

HCT [offers patients with this condition only chance of cure?] **OR** [is the standard of care for this condition].

Transplant for [X condition] is accepted as the standard of care, and is well supported by respected scientific literature. [Summarize literature findings here.]

Please review the following enclosed medical journal articles that support this position:

* **Article #1**
* **Article #2**
* **Article #3**

**OR**

Due to the small number of patients with this [deadly? rare?] disease it is not possible to obtain enough participants for a clinical trial, hence we must rely on small case series to guide treatment. [Summarize published findings.] [Explain why you are taking the approach you are.]

* **Article #1**
* **Article #2**
* **Article #3**

Based on the available medical literature on [Patient's Name's] condition, I am filing this appeal, specifically requesting that you approve the required [HCT that was denied]. Transplant is the [only available **OR** best available] treatment for this condition and for this patient. Not approving this transplant leaves this patient with [insert prognosis here].

Sincerely,

[Physician's Name]**, M.D.**

**Enclosures:**

* Documents referred to in text
* Signed Authorization of Representative Form