Instructions:

This template is offered as a resource a healthcare provider could use when responding to a request from a patient's health benefits company to provide a letter of medical necessity for prescribing AstraZeneca or MedImmune medicines. **Attachments to be included with the letter of medical necessity are [original claim form, copy of denial or explanation of benefits, and any other additional supporting documents**.] If you need additional references, please contact our information center at 1-800-236-9933.

Use of the letter does not guarantee that the insurance company will provide reimbursement for AstraZeneca or MedImmune medicines, and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Template:

[Date]

[Contact - usually the medical director]
[Title]
[Name of Health Insurance Company]
[Address]
[City, State, ZIP Code]

Insured: *[Name]*
Policy Number: *[Number]*
Group Number: *[Number]*

Dear *[Name of Contact]:*

I am writing on behalf of my patient, *[name of patient]*, to appeal *[name of health insurance company]*'s decision to deny coverage for *[name of medicine]* which is prescribed to *[reason for prescription]*. This letter documents the medical necessity for this medicine and provides information about the patient's medical history and treatment.

It is my understanding based on your letter of denial dated, *[date]*, that coverage has been denied for the following reason(s):
[List the specific reason(s) for the denial as stated in the denial letter.]

Patient History and Diagnosis
[Provide a brief description of the patient's medical condition here.]
[Include a short summary of the patient's medical history.]
[Explain why you believe it is medically necessary for patient to receive this medicine.]
[Describe the potential consequences of the patient if they do not receive this medicine.]
[Obtain and attach supporting letters of medical necessity from any specialist that is or has provided care to the patient.]

[name of medicine] **Indication Information**

[Include medicine indication information]

[Include medicine administration information]

In summary, *[name of medicine and reason for prescription]* is medically necessary for this patient. Please contact me at *[physician telephone number, including area code]* if any additional information is required to ensure the prompt handling of this request and/or payment of the associated claims for *[name of patient]*.

Thank you in advance for your immediate attention to this written appeal.

Sincerely,

[Physician's Name]
[Physician's Practice Name]

References

[Include medicine PI]

[Include other relevant references and publications regarding medicine]