SAMPLE LETTER OF APPEAL TEMPLATE

To be considered when appealing a
denied claim or pre-authorization

Instructions for completing the sample appeal letter:

1. Please customize the appeal letter template based on the medical appropriateness. Fields required for customization are in **RED**.
2. It is important to provide the most complete information to assist with the appeal of a prior authorization denial.
3. After you have customized the appeal letter, ***please make sure to delete*** any specific instructions for completion, disclaimers, Abbott logos, caution statement, tradegraphs and document number that are seen throughout the letter so the health plan does not misinterpret the information.
4. For independent consideration and review; please make all changes that you believe appropriate, or disregard these suggestions in their entirety. The customer is ultimately responsible for the accuracy and completeness of all claims submitted to third-party payers. Please see the FDA-approved label for information relevant to any prescribing decisions.

[Physician Letterhead]

[Date]

Attention: Appeals Department
Reference Number: *[_____]*
[Payer contact name]
[Payer contact title]
[Payer]
[Street address]
[City, State, zip code]

Re: Request for Reconsideration of Denied Claim or Pre-Authorization

Patient name: *[First and last name]*
Patient date of birth: *[XX/XX/XXXX]*
SS # *[XXX-XX-XXXX]*
Insurance ID # *[XXXXXXXXXXXXXXX]*
Group # *[XXXXXXXXXX]*
Date of Service: *[XX/XX/XXXX]*
CPT‡ Code:
*[**93580** – Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant]*

For physician and outpatient facility billing, if billing Medicare or Medicare Advantage, the facility may also report:
[C1817 Septal defect implant system, intracardiac]

Inpatient for any payer:
***[02U53JZ** – Supplement atrial septum with synthetic substitute, percutaneous approach]*

Dear *[Payer contact name]*:

I am writing to request *reconsideration of the denial of prior authorization* for the above-referenced service. The service to be provided is a medically necessary implant of the Amplatzer™ PFO Occluder on an *[inpatient / outpatient]* basis to be provided to *[patient's name]* on *[procedure date]*.

In my last communication, I explained why the Amplatzer™ PFO Occluder is medically necessary to reduce the risk of secondary stroke in this otherwise healthy patient. I urge you to reconsider your denial of prior authorization in light of the patient's specific clinical need, as well as the evidence for this technology, including its FDA approval.

To further substantiate my request please note that an Amplatzer™ PFO Occluder is medically necessary for this patient based on a comprehensive neurological assessment which determined this patient suffered from an ischemic stroke of undetermined etiology – the so called cryptogenic stroke. As described in my earlier request, documentation by the referring physician, in addition to my examination, supports the determination of this patient's need for PFO closure.

[Insert paragraph explaining, in your own words, why the PFO closure is medically necessary for this patient. Consider documenting how the patient's condition reflects the on-label use of the product; why less extensive interventions are inadequate in light of the patient's condition; and your expectations of the patient's outcomes without the PFO closure procedure. Please remember that the Amplatzer™ PFO Occluder is FDA approved to be used for the following indications: percutaneous transcatheter closure of a patent foramen ovale (PFO) to reduce the risk of recurrent ischemic stroke in patients, predominantly between the ages of 18 and 60 years, who have had a cryptogenic stroke due to a presumed paradoxical embolism, as determined by a neurologist and cardiologist following an evaluation to exclude known causes of ischemic stroke. Where accurate, please describe how the intended use is consistent with the FDA approved indication.]

I am attaching the patient's medical record information and letter of medical necessity from my previous request.

[Include the following statement if additional information to be attached]

In addition to my prior communication, I have attached *relevant excerpts from the patient's ongoing medical record, a summary of clinical evidence with references from peer-reviewed medical journals*, etc.

As explained above, I believe that in this case the Amplatzer™ PFO Occluder implant is medically necessary for this patient and as such this service should be granted coverage and paid for by your organization accordingly.

Please let me know if I can provide any additional information, and thank you for your attention.

Sincerely,

[Physician's name and credentials]
[Title]
[Name of practice]
[Street address]
[City, State, zip code]
[Phone number]

Enclosures:
[Patient medical records/chart notes]
[FDA Approval letter – Amplatzer™ PFO Occluder]
[Evidence summary and select literature]

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