**SAMPLE APPEAL LETTER FOR DENIED CLAIMS TEMPLATE**

Insertable Cardiac Monitor (ICM)

**Instructions for completing the sample appeal letter for denied claims:**

1. Please customize the appeal letter template based on the medical appropriateness. Text requiring customization is in **RED**.
2. After you have customized the letter, ***please make sure to delete this page and any specific instructions*** for completion, disclaimers, Abbott logos, caution statement, trademarks and document number that are seen throughout the letter.
3. For independent consideration and review, please make all changes that you believe appropriate or disregard these suggestions in their entirety. The healthcare provider 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.

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*[Physician Letterhead] [Date]*

Attention: Appeals Department

Reference Number: *[ ] [Payer contact name]*

*[Payer contact title]*

*[Payer]*

*[Street address]*

*[City, State, zip code]*

**Re: Reconsideration of Claims Denial *(enter number)* for subcutaneous cardiac rhythm monitor insertion**

Patient name: *[First and last name]*

Patient date of birth: *[XX/XX/XXXX]*

Insurance ID # *[XXXXXXXXXXXXXXX]*

Group # *[XXXXXXXXXX]*

Date of Service: *[XX/XX/XXXX]*

***CPT Code****:*

* ***33285****, Insertion, subcutaneous cardiac rhythm monitor, including programming*

Dear *[Payer contact name]*:

I am writing to request *reconsideration of the denied claim, [claim #],* for the above-referenced service. The service was a medically necessary insertion of the Assert-IQTM insertable cardiac monitor, provided to *[patient’s name]* on *[procedure date]*.

The request for prior authorization was submitted prior to the procedure [date of submission], and approved on [date of approval], [enter reference #/prior authorization approval letter #]. The claim, however, is now denied due to *[enter denial reason].* *If claim was denied due to procedure falling outside of allowable timeline given on original prior authorization approval, explain in detail why procedure took place prior or after.*

I urge you to reconsider your denial of the claim in light of the patient’s specific clinical need, as well as the evidence for this technology.

The FDA approved Insertable Cardiac Monitor is capable of monitoring and performing diagnostic valuation of patients who experience unexplained symptoms that may be cardiac-related such as: dizziness, palpitations, chest pain, syncope, and shortness of breath, as well as patients who are at risk for cardiac arrhythmias such as bradycardia, tachycardia, and sinus pauses. The ICM is also indicated for patients who have been previously diagnosed with atrial fibrillation (AF) or who are susceptible to developing AF. It is intended to be inserted subcutaneously in the left pectoral region, also described as the left anterior chest wall.

[If applicable] Documentation by the referring physician, as well as my examination, supports the determination of this patient’s need for the insertable cardiac monitor.

*[Insert paragraph explaining, in your own words, why Assert-IQ is medically necessary for this patient. Where accurate, consider documenting how the patient’s condition reflects the on-label use of the product; why more extensive interventions are inadequate in light of the patient’s condition; your expectations of the patient’s outcomes without the ICM procedure; how patient’s way of life and/or medical condition has benefited already from the procedure itself]*

I am attaching the patient’s medical record information and letter of medical necessity from my initial and approved request.

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

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 in this case that the ICM insertion is and was medically necessary for this patient and as such this service should be granted coverage and reimbursed by *(insert name of insurance company)* 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:

*[Copy of original Prior Authorization approval letter]*

*[Patient medical records/chart notes]*

*[FDA Approval letter]*

*[Evidence summary and select literature]*