Denial Letter Template

1. Replace all red highlights with requested information in black.
2. Remove this heading.
3. Print final document on official practice/physician letterhead.

This document is being provided solely for informational purposes and for your independent consideration and review. You should make any and all changes that you believe are appropriate, or disregard these suggestions in their entirety. Arthrex makes no assurances that the use of this letter will guarantee coverage or reimbursement of any item or service. The provider of services has the sole responsibility to determine medical necessity and to submit appropriate codes and charges for care provided in accordance with the particular payor or payors' requirements.

Date

<Contact Name>
<Title>
<Insurance Company Name>
<Payor Address>

RE: <Patient Name>
<Patient's Date of Birth>
<Patient's Insurance Policy Information>

Dear <Contact Name>,

I am writing in response to your denial of the enclosed claim provided on <date of service> for <procedure name> to treat <diagnosis>. <Insurance company name> has denied payment for this treatment for <patient name> for the following reason(s) listed on the attached <denial letter or explanation of benefits>: <list the denial reason(s) on the denial letter or explanation of benefits, denial codes, and definition>. I am submitting the claim for reconsideration, based upon my independent clinical assessment. This letter provides information about the patient's medical history and diagnosis, and includes a statement summarizing my treatment rationale.

<Procedure name> is a <briefly describe procedure> for the treatment of <diagnosis>. The history of this patient's condition is as follows.

<As appropriate, and based on your independent clinical assessment, consider inserting information regarding the patient's pertinent medical history information, potentially including:>

- Diagnosis
- Duration of related symptoms
- If applicable, any prior failed conservative treatments or reasons symptoms were not alleviated
- Any impact on patient's quality of life
- Anticipated outcome and medical benefit of desired treatment
- Need for the treatment

For this surgical procedure, I <plan to use/ used> autologous chondrocyte transplantation that combines articular cartilage with an extracellular matrix, to repair and reinforce the <name injury/damage>. Please refer to enclosures for peer-reviewed literature in support of this osteochondral repair technique. Based on my own independent clinical judgment, I believe that this surgical procedure is medically necessary and an appropriate treatment for this patient.

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I am enclosing documentation supporting the medical necessity of this treatment for this patient. Please contact me at <requesting physician's direct telephone number> if you require additional information or would like to discuss the case in greater detail. Thank you for your timely response.

Sincerely,
<Physician's Name>
<Physician's Address>

Enclosures (attach supporting literature)