

EXAMPLE LETTER ONLY

Date:
Contact (usually the Medical Director):
Title:
Name of health insurance:
Address:
City, State, Zip:
Patient/Insured name:
Patient ID:
Policy number:
Group number:

Claim Rebuttal Narrative

Dear Dr. (Medical Director's name),

I am writing to you on behalf of my patient, (Patient name), to request reconsideration of a claim. ATRIDOX® (doxycycline hyclate) 10% was provided to (Patient name) on (date of service). (Patient name) has been under my care for treatment of periodontal disease since (insert date). You have indicated that ATRIDOX® is not covered by (insurance company) because (insert reason for denial from Explanation of Benefits).

ATRIDOX® is indicated for the management of adult periodontal disease. Due to the presence of periodontal disease, I have administered ATRIDOX® as an essential part of (his/her) treatment. I would appreciate a reconsideration of the claim from (date of service) for (Patient name). To further support the necessity of this patient's treatment with ATRIDOX®, I am including the following information:

(List additional information attached to appeal including patient history, diagnosis, past treatments and product information such as package insert).

Based on the above facts, treatment with ATRIDOX® is appropriate for this patient. I would appreciate a reconsideration of this claim. If you have any further questions, please call me at (doctor's telephone number, including area code) to discuss. Thank you in advance for your immediate attention to this request.

Sincerely,

(Dr. name)
(Practice name)
(State license #)

Enclosures:
Patient history
Diagnosis, past treatments
ATRIDOX® full prescribing information