[Date]

Via Facsimile – [Fax No#]

[Insurance Company and/or Managed Behavioral Health Company]
[Member Services Dept. or other applicable dept.]
[Address, if needed]

Dear [Member Services or other applicable dept.]:

My name is [insured patient's name] and I am insured under policy # [insert policy #] and group # [insert group #]. My plan is governed by the Federal Mental Health and Addiction Parity law.

I am currently a patient at [insert name of provider] and I hereby request a copy of the medical necessity criteria and specific reasons for denial that you are relying on in denying reimbursement for my treatment services at the following level(s) of care:

[ ] detoxification
[ ] inpatient rehab
[ ] residential
[ ] partial hospitalization
[ ] intensive outpatient

I have paid for this benefit and [insert name of provider] is licensed by the state of [insert state] [and accredited, if applicable] to provide these treatment services. My attending physician has admitted me to this/these level(s) of care and is recommending my continued treatment. I am in dire need of these treatment services and they are covered by my benefit plan and should be paid for.

I request that you immediately fax the medical necessity criteria and specific reasons for denial that you rely on in reaching a different medical decision than my treating physician and refusing to cover my treatment services. **Please fax the medical necessity criteria and specific reasons for denial to my attention at fax # [insert #].** If you would like to speak with me, please contact [insert name of applicable care provider contact].

Sincerely,

[Patient's name]