

Letter of Appeal

To:

ATTN: Claims Department

Re: Patient's Name:
Policy Number:
Treatment Date(s):
Amount:

Dear Director of Claims,

The above referenced claim was denied on _____ despite the fact that our office verified benefits and obtained prior authorization of care from your plan on _____.

_____ has been treated for _____
with the following treatment modalities:

PuraPly™ Antimicrobial (PuraPly AM) has been FDA cleared since 2005. It is my belief that _____ has benefited from PuraPly AM treatment and therefore the services rendered should be covered under his/her plan. Please feel free to contact me if you require additional information to reconsider your coverage decision.

Sincerely,