[Your name]
[Your address]
[Your city, state, ZIP]
[Your phone number]
[Tax ID#]

[Date]

[Name of Health Insurance Company]
[Address of Health Insurance Company]

Re: Request for Reconsideration of LEQEMBI® (lecanemab-irmb) use for [patient name]

Member ID:
Group or Medicare #:
Claim or Explanation of Benefit #:

To Whom It May Concern:

I am writing on behalf of my patient, [patient's name], to appeal your denial of coverage for treatment with LEQEMBI® (lecanemab-irmb) injection, for intravenous use. The above claim was denied as [not medically necessary, not covered on the medical benefit, etc.]. We are requesting a redetermination of the denial of coverage for LEQEMBI.

[Outline the patient's history, diagnosis, and treatment plan. Provide rationale for LEQEMBI treatment.]

For the reason provided above, I believe that LEQEMBI should be covered by [payer name] for this patient. Enclosed please find relevant documentation to support this request for redetermination.

Kindly contact me at [phone number] if you need any additional information or would like to discuss this further. Thank you for your prompt attention and consideration of this matter, and for your anticipated approval for LEQEMBI in the treatment of [patient's name].

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Sincerely,

[Physician Name]

Enclosures [suggested]: supportive medical records