**[Date]**

**[Insurance Company Name]**

**[Appeals and Grievances Department]**

**[123 Apple Street]**

**[Anytown, VA 12345]**

**RE: [Your Name]**

**[Member ID #]**

**[Reference # on Explanation of Benefits]**

**[Your Date of Birth]**

Dear **[Payer]** Appeals Department,

My name is **[Your Name]**, and I am writing to formally appeal the denial of my pneumatic compression therapy as outlined in the Explanation of Benefits dated **[Date]**.

I was diagnosed with lymphedema on **[Date]**. This condition has significantly impacted my daily life in **[briefly explain symptoms and identify specific tasks or activities that you have trouble doing, such as walking to your mailbox, cleaning your house, wearing shoes, going to social events]**. My doctor, **[insert Doctor's Full Name]**, has provided a Letter of Medical Necessity that details the clinical benefits of the prescribed pneumatic compression therapy for my specific case. Dr. **[Doctor's Last Name]** emphasizes in the letter, "**[Include a key statement from the letter supporting treatment]**."

I kindly request that you review the attached documents, including my physician’s Letter of Medical Necessity, to gain a comprehensive understanding of my medical history and the necessity of the prescribed treatment.

Given the thorough assessment by Dr. **[Doctor’s Name] and** the documented medical justifications for the prescribed pneumatic compression therapy, I am hopeful that **[Payer's Name]** will reevaluate the decision to deny me access to this essential therapy. This treatment is what my physician recommends for managing my chronic lymphedema and improving my health.

If there are any additional details or supporting information required, please do not hesitate to contact me at **[Your Phone Number]** orreach out to Dr. **[Doctor's Last Name]** at **[Doctor's Phone Number]**. Your prompt attention to this appeal is highly appreciated.

Thank you for your time, understanding, and consideration of this matter. I am hopeful for a positive resolution that prioritizes my health and well-being.

**[Your Name]**

**[Your Address]**

**Enclosures:**

1. Explanation of Benefits document dated **[date]**

2. Doctor’s Letter of Medical Necessity

3. Medical Records

4. Documents explaining procedure and its efficacy

5. Supportive Journal Articles

6. Location of Edema Photos

CC: **[Name of Treating Doctor]**