SAMPLE LETTER OF APPEAL - This sample is provided for informational purposes only. Use of this sample is not a guarantee of reimbursement. Please check with the patient's plan for additional requirements.

Instructions: follow individual payers' requirements for preparing and submitting appeals. Although this template letter is intended to support the appeal process, you may need to comply with payer-specific requirements. Providers are responsible for customizing the letter to reflect the unique background and diagnosis of a particular patient, as well as the special requirements of the particular payer involved. The provider is responsible for ensuring the medical necessity of the procedure.

Recommended Attachments: [original claim form, copy of denial or explanation of benefits (if applicable), copy of patient's insurance card, LUTATHERA Prescribing Information, FDA approval letter, etc.]

[DATE]

[PAYER NAME]

[PAYER ADDRESS 1]

[PAYER ADDRESS 2]

[PAYER CITY] [STATE] [ZIP]

[PAYER FAX NUMBER]

Attn: _____
APPEALS DEPARTMENT

RE: _____
INSERT PATIENT NAME

Date of Birth: _____
INSERT PATIENT'S DOB

Policy ID/Group Number: _____
INSERT POLICY ID/GROUP NUMBER

Plan Number: _____
INSERT PLAN NUMBER

Policy Holder: _____
INSERT POLICY HOLDER'S NAME

Date of Service: _____
INSERT DATE OF SERVICE

Claim Number: _____
INSERT CLAIM NUMBER

To Whom It May Concern:

I am requesting an expedited appeal for medically necessary services prescribed to _____
INSERT PATIENT NAME

for therapy with LUTATHERA® (lutetium Lu 177 dotatate) injection for intravenous use on_____.
DATE OF SERVICE

_____ denied a claim in the amount of _____ on _____
NAME OF HEALTH INSURANCE COMPANY DOLLAR AMOUNT OF CHARGES DATE(S) OF SERVICE

due to _____.
SUMMARIZE INSURER'S STATED REASON FOR CLAIM DENIAL

LUTATHERA is indicated for the treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut and hindgut neuroendocrine tumors in adults.

Because _____ has been diagnosed with _____ as of _____, and
NAME OF PATIENT PATIENT'S DIAGNOSIS DATE OF DIAGNOSIS

PROVIDE A BRIEF DISCUSSION OF PATIENT'S RELEVANT MEDICAL HISTORY, CONDITION/SYMPTOMS AND THERAPY TO DATE, INCLUDING OTHER TREATMENTS ATTEMPTED AND RESULTS

I believe LUTATHERA is medically necessary and a clinically appropriate treatment for _____.
NAME OF PATIENT

Thank you, in advance, for your review and consideration of this appeal. If you have any questions or require additional information regarding this case, please contact me at _____.
PHYSICIAN'S TELEPHONE NUMBER

Sincerely,

_____ _____
PHYSICIAN'S NAME PHYSICIAN'S SIGNATURE

_____
CONTACT INFORMATION

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