Denied to Approved: Infusion Appeals Submission Checklist

(Use this checklist to increase your approval success rate and minimize delays.)

1. Gather All Appeal Materials

- Copy of original denial letter (with reason for denial)
- Completed Appeal Letter (template provided)
- Letter of Medical Necessity from ordering physician
- Clinical progress notes supporting diagnosis and need
- Relevant diagnostic reports (labs, imaging)
- Copy of prior authorization approval (if applicable)
- Prescribing Information (optional but recommended)

2. Verify All Patient and Insurance Details Are Correct

- Patient Name, DOB, Insurance ID, Dates of Service
- Authorization Number (if applicable)
- Correct insurance company appeal address
- Practice name, NPI, and contact information included

3. Highlight Medical Necessity Clearly

- Diagnosis matches the drug indication
- Prior treatments tried and failed are listed
- Guideline support (ex: ACR, AGA, FDA approval noted)
- Clearly state risk of delayed treatment

4. Package the Appeal Professionally

- Neatly organize documents (appeal letter first, supporting docs behind)
- Use clean, readable fonts (like Arial, Calibri, Montserrat)
- Save and send as a single PDF if submitting electronically
- Print and use a cover sheet if mailing

5. Confirm Submission and Follow Up

- Submit appeal via the correct method (fax, portal, mail) based on payer's instructions
- Save a copy of all submitted materials
- Set a follow-up reminder for 7–10 business days after submission
- Call to verify receipt and check status

Quick Pro Tip:

"Always keep notes of who you spoke to, when, and what was said. Insurance follow-up wins appeals!"

[Appeals Letter Template]

[Practice Letterhead or Logo Here]

Date: [Insert date]

To: [Insurance Company Name]

Attention: Appeals Department

Address: [Insurance Company Address]

City, State, Zip Code

Re: Appeal for Denied Authorization/Claim

Patient Name: [Insert Patient Name]

Patient DOB: [Insert Date of Birth]

Insurance ID #: [Insert Member ID]

Date(s) of Service: [Insert Service Date(s)]

Authorization Number (if applicable): [Insert Authorization Number]]

Subject: Appeal for Reconsideration — Medical Necessity of [Drug Name] Treatment

Dear Appeals Reviewer,

I am writing to formally appeal the denial of coverage for [Insert Drug Name], administered/proposed for [Insert Diagnosis or Condition (e.g., rheumatoid arthritis, multiple sclerosis, Crohn's disease, osteoporosis)] for our patient listed above.

The denial was issued on [Insert Date of Denial] with the stated reason: [Insert denial reason: e.g., "lack of medical necessity," "experimental/investigational," "no prior authorization obtained," etc.]

We respectfully request reconsideration and overturn of this decision based on the following:

Medical Necessity and Supporting Information:

- Diagnosis: [Insert Diagnosis]
- Drug/Infusion Ordered: [Insert Drug Name, Strength, Dosage]
- Administration Details: [IV/Infusion/SubQ; Frequency]
- Prior Authorization Status: [Approved/Requested/Retroactive Request]

• Clinical Rationale:

• Patient meets [FDA-approved indications / guideline-supported usage per ACR, AGA, or other relevant professional guidelines].

• Prior therapies have been trialed and failed (if applicable): [List prior medications].

• [Insert any lab values, imaging studies, or clinical markers supporting diagnosis/severity.]

Attachments Included:

• Letter of Medical Necessity from Physician

• Clinical Progress Notes

• Relevant Lab/Diagnostic Reports

• Copy of Prior Authorization Approval (if applicable)

• Copy of Denial Letter

• FDA Prescribing Information for [Drug Name] (optional)

We respectfully request immediate reconsideration of this claim/authorization request in light of the medical documentation provided. Prompt approval is critical to prevent disease progression, avoid worsening symptoms, and maintain the patient's quality of life.

Please feel free to contact our office at [Phone Number] should you require any further information.

Thank you for your timely attention to this appeal.

Sincerely,

[Your Name]

[Your Title, e.g., Infusion Coordinator, Billing Specialist, Office Manager]

[Practice Name]

[Phone Number]

[Letter of Medical Necessity Template]

[Practice Letterhead or Logo Here]

Date: [Insert Date]

To: [Insurance Company Name]

Attention: Utilization Management Department

Address: [Insurance Company Address]

**City, State, Zip Code]

Re: Letter of Medical Necessity for [Patient Name]

Patient Name: [Insert Patient Name]

Patient DOB: [Insert Date of Birth]

Insurance ID #: [Insert Insurance ID #]

Date(s) of Service / Proposed Start Date: [Insert Date(s)]

Physician Name: [Insert Physician Name]

NPI Number: [Insert NPI]

Dear Utilization Reviewer,

I am writing to request authorization/coverage for [Insert Drug Name] for my patient, [Insert Patient Name], who is under my care for [Insert Diagnosis (e.g., rheumatoid arthritis, Crohn's disease, multiple sclerosis, osteoporosis)].

Clinical Summary:

[Insert Patient Name] has a confirmed diagnosis of [Insert Diagnosis] based on [Insert Diagnostic Tests, e.g., lab results, imaging studies, physical exam findings].

The patient has exhibited [Insert symptoms — e.g., progressive joint erosion, elevated inflammatory markers, persistent neurological deficits, etc.].

Treatment History:

Previous therapies attempted: [Insert list of drugs tried, durations, and outcomes]

Reason for switching/escalating therapy: [Insert reason, e.g., lack of efficacy, intolerance, disease progression]

Recommended Treatment Plan:

Requested Medication: [Insert Drug Name]

Dosage and Frequency: [Insert dosage, frequency, and route (IV/SubQ)]

Duration: [Insert anticipated length of therapy]

Medical Justification:

[Drug Name] is FDA-approved for the treatment of [Insert Diagnosis] and is recommended by [Insert Relevant Guidelines — e.g., American College of Rheumatology (ACR), American Gastroenterological Association (AGA), etc.].

The patient has failed prior therapies and now requires [Insert Drug Name] to prevent further progression, disability, and/or complications.

Delayed treatment will likely result in [Insert risks: irreversible damage, hospitalization, diminished quality of life].

Attachments Provided:

Clinical Progress Notes

Diagnostic Reports (Labs, Imaging)

Prior Authorization Form (if applicable)

Relevant Medical Literature (optional)

It is medically necessary that [Insert Patient Name] receives [Insert Drug Name] at this time to effectively manage their condition and avoid preventable worsening of their disease.

If additional information is required, please contact me directly at [Phone Number].

Thank you for your prompt review and consideration.

Sincerely,

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]

[Phone Number]