

Dear Dr.

I am writing to request a formal appeal of a denial of benefits to which I believe I am entitled under my coverage.

I have been treated for symptomatic cervical disc disease (SCDD) for and I failed to have a resolution to my pain.

Dr. _____ and I have determined that cervical disc arthroplasty is appropriate for my condition and that I meet all of the criteria for a successful surgery.

The cervical disc arthroplasty is medically necessary, and is the most appropriate treatment for my condition. I am enclosing my medical history, which I believe you have received from Dr. _____ as well.

I am appealing the denial of benefit and am submitting this letter to provide details on my case. I am including clinical information/ medical history as well as the FDA approval letter and clinical literature for your review. I am also enclosing a consent form in which I authorize you and anyone involved in this review to disclose any information on this case to my authorized representative who will assist in this appeal process.

Please find the enclosed documentation that may be helpful in your reconsideration of this claim:

- A copy of the denial
- Medical history
- Clinical literature on disc arthroplasty
- Medical justifications for disc arthroplasty
- FDA approval letter
- Patient consent form

Thank you for your reconsideration of coverage.

Please contact me at _____ if I may be of further assistance.

Sincerely,