

Sample Patient Appeal Letter for Urgent[®] PC

Name of the Insurance Company
Address

Patient
Policy Holder
Insurance ID/Soc. Security

Re: PTNS Coverage Denial

Dear _____:

My name is [insert name]. I am appealing your recent denial of coverage for my Percutaneous Tibial Nerve Stimulation (PTNS) therapy. I have attached a copy of your notice, dated [insert date of denial letter], in which the reason given for denial is that the "therapy is considered investigational/experimental." I request that you reverse your decision immediately.

I understand that current clinical information about PTNS suggests that insurance coverage is both appropriate and necessary. Successful PTNS could mean that symptoms of my [insert diagnosis] would be reduced, and I would possibly be able to resume my previous, active lifestyle.

My physician has indicated that PTNS using the Urgent[®] PC Neuromodulation System is a proven therapy for the treatment of urinary urgency, urinary frequency, and urge incontinence, symptoms often referred to as Overactive Bladder (OAB) and often associated with Interstitial Cystitis (IC). The FDA cleared the first device for PTNS therapy in January 2000. During the past years PTNS has become a standard of care for patients, like myself, who suffer from these urinary symptoms.

My physician has explained that PTNS using Urgent PC therapy is minimally-invasive neuromodulation that is delivered through a thin needle placed in my inner ankle. Impulses from the Stimulator travel through the Lead Set and into my ankle. The impulses then travel along the tibial nerve to the sacral nerve plexus, an area of the body associated with bladder regulation and pelvic floor function. PTNS therapy is delivered in 30-minute weekly sessions for 12 weeks, with maintenance therapy customized for each patient.

As you reconsider reversing your decision, let me tell you about other treatments I have undergone that you have covered and why they have not worked for me.

(Personalize the letter. You may require one or more paragraphs for each of the headings listed below.)

Talk about your condition. How long have you suffered from it?

Talk about the effects of your condition and the specific limitations you experience as a result of your condition, such as the physical and emotional effects. Discuss the debilitating challenges you face in your daily life. Tell how your life has been affected by your condition, noting changes in social activity, family life and your ability to work effectively. Note other limitations that restrict your quality of life. Mention any feelings you may have had, and what you must do to cope with your condition.

Write about other therapies you have tried (such as diets, exercises and medications) and include the results. Talk about any side effects you experienced when taking oral medications. Point out

other options you may have considered and why they are not acceptable. You may need more than one paragraph.

My doctor, [insert doctor's name], has recommended PTNS therapy as the best available treatment for me. Research, clinical studies, and patient outcomes support [his/her] recommendation. I am very hopeful that PTNS therapy will help me lead a more normal life once again. [Give examples of the particular limitations of your condition and what activities you hope to be able to participate in after the treatment.] Given the treatment methods available, Percutaneous Tibial Nerve Stimulation is the most appropriate choice based on my physician's medical advice. Please reverse your denial, and allow me to receive PTNS therapy with the Urgent® PC Neuromodulation System.

I look forward to hearing from you very soon. I will contact you on [insert date] to learn what else must be done to reverse your decision.

Sincerely,

[Insert name]

[Insert phone number]

Sample Patient Appeal Letter for Macroplastique®

Name of the Insurance Company
Address

Patient
Policy Holder
Insurance ID/Social Security Number

Re: Bulking Agent Coverage Denial

Dear _____:

My name is [insert name]. I am appealing your recent denial of coverage for my bulking agent treatment. I have attached a copy of your notice, dated [insert date of denial letter], in which the reason given for denial is that “[give their reason(s)].” I request that you reverse your decision immediately.

I understand that current clinical information about bulking agent treatment suggests that insurance coverage is both appropriate and necessary. Successful treatment with a bulking agent could mean that symptoms of my [insert diagnosis] would be reduced, and I would possibly be able to resume my previous, active lifestyle.

My physician has indicated that bulking agent treatment is injected into the tissues surrounding the urethra. The increased “bulk” allows urethra to close more effectively and prevents urine from leaking.

As you reconsider reversing your decision, let me tell you about other treatments I have undergone that you have covered and why they have not worked for me.

(Personalize the letter. You may require one or more paragraphs for each of the areas listed below.)

Talk about your condition. How long have you suffered from it?

Talk about the effects of your condition and the specific limitations you experience as a result of your condition, such as the physical and emotional effects. Discuss the debilitating challenges you face in your daily life. Tell how your life has been affected by your condition, noting changes in social activity, family life and your ability to work effectively. Note other limitations that restrict your quality of life. Mention any feelings you may have had, and what you must do to cope with your condition.

Write about other therapies you have tried (such as exercises and medications) and include the results. Talk about any side-effects you experienced when taking oral medications. Point out other options you may have considered and why they are not acceptable.

My doctor, [insert doctor's name], has recommended Macroplastique® as the best available treatment for me. Research, clinical studies, and patient outcomes support [his/her] recommendation. I am very hopeful that bulking agent treatment will help me lead a more normal life once again. [Give examples of the particular limitations of your condition and what activities you hope to be able to participate in after the treatment.] Given the treatment methods available, Macroplastique is the most appropriate choice based on my physician's medical advice. Please reverse your denial and allow me to receive treatment with Macroplastique.

I look forward to hearing from you very soon. I will contact you on [insert date] to learn what else must be done to reverse your decision.

Sincerely,

[Insert name]

[Insert phone number]