HYALGAN® SAMPLE LETTER OF APPEAL

Below is a sample, template letter of appeal that may be customized with patient-specific information and submitted to payers for reconsideration of denied claims. For additional assistance, please call the *HYALGAN® Support Hotline* at **1-866-7-HYALGAN (1-866-749-2542)**, Monday to Friday, from 9:00 AM to 8:00 PM EST.

[Date]
[Name of Medical Director]
[Insurer Name]
[Address]
[City, State, Zip Code]

Re: [Patient Name]
[Patient ID Number]
[Claim Number]

Dear Dr. [Name of Medical Director]:

I am writing to formally appeal a denied claim for services provided to [insert patient's name, ID number, and claim number]. Based on a clinical assessment of my patient, the patient's diagnosis, and medical history, HYALGAN® (sodium hyaluronate) therapy is medically necessary. This letter provides my clinical rationale for HYALGAN® therapy. It presents information about this patient's medical condition and explains why it is medically necessary and appropriate for this patient.

[Insert patient's case history, including the patient's condition and clinical course prior to HYALGAN® therapy.]

Based on the clinical evidence for this case, HYALGAN® therapy is medically necessary. Accordingly, this claim should have been approved for payment.

I hope that this letter has been helpful in explaining the necessity and value of HYALGAN® therapy for this patient. I have enclosed the following documents to assist you in your reconsideration of this claim:

- A copy of the denied claim;
- Clinical literature on HYALGAN® therapy and the clinical benefits; and
- [any additional, relevant information to support the appeal, such as medical notes or payer policy].

Thank you for your reconsideration of coverage for this patient's treatment. Please call me at [insert phone number] if additional information is required.

Sincerely,

[Physician's name]