<Date>

<Payer Name>
<Payer Address>
<Payer City, State and zip>

Regarding: <Patient First and Last Name>
HIC Number: <Patient HIC #>

Date of Service	**Procedure Code**	**Billed Amount**	**Claim Number**	**Denial Date**
<Date of Service>	<Procedure Code>	**$** <Billed amount>	<Claim Number>	<Denial Date>

To Whom It May Concern:

Based on the information in the *Medicare Carriers Manual*, section 2049.4C, I am requesting a redetermination by an Oncology Medical Advisor of the denial of the above-referenced line item(s).

The case in question involves a Patient with <ICD-10 code> <diagnosis name> cancer using a treatment regimen of <drug name>. The enclosed literature relates to the use of <drug name> for <ICD-10 code> <diagnosis name> cancer and/or similar cell type diagnosis.

The following items are enclosed:

- Medical literature regarding the use of <drug name> for <ICD-10 code> <diagnosis name> cancer and/or similar cell type diagnosis
- Relevant clinical documentation such as: history and physical, progress notes, treatment history, Letter of Medical Necessity (LOMN)
- Copies of the Explanation of Medicare Benefits (EOMBs)
- Compendia listings, if applicable

In view of the above information in the attached appeal packet, I believe all claims should be covered and paid.

Sincerely,

<Provider Signature>
<Provider Name>