GLP-1 INSURANCE APPEAL LETTER - EDITABLE TEMPLATE
Fill in the [bracketed] fields. This is a general template for personal use.

[Your Full Name]
[Your Street Address]
[City, State ZIP]
[Phone] | [Email]
Member/Subscriber ID: [ID]
Date: [Date]

[Insurance Company Name]
[Appeals Department Address]

Re: Appeal of coverage denial for [medication, e.g., Wegovy / Zepbound / Ozempic]
Member: [Your Name] Member ID: [ID] Claim/Reference #: [Number]

To the Appeals Review Team:

I am formally appealing the denial dated [Denial Date] for coverage of [medication], prescribed by [Prescriber Name] for the treatment of [diagnosis, e.g., obesity with BMI [__], or type 2 diabetes].

Reason stated for the denial: [copy the exact reason printed on your denial letter].

I am asking you to reconsider this decision for the reasons below.

1. Medical necessity. My prescribing clinician has determined this medication is medically appropriate for my condition. Enclosed supporting documentation: [ ] letter of medical necessity, [ ] chart notes, [ ] BMI and weight history, [ ] relevant lab results, [ ] record of prior weight-management attempts.

2. Plan criteria met. I meet my plan's stated coverage criteria: [list each criterion your plan requires and how you meet it - for example BMI threshold, a comorbidity such as hypertension, sleep apnea, or prediabetes, and any required prior lifestyle program].

3. Prior treatments tried. I have previously tried [diet and exercise program, other medications, etc.], as documented, without an adequate or lasting result.

Please review the enclosed records and reconsider this denial so the prescription can be filled. If additional information is needed, please contact me or my prescriber at [phone / fax].

If this internal appeal is not approved, please send me instructions for requesting an external review by an independent reviewer, as provided under my plan and applicable law. Please also confirm the deadline for my next appeal step.

Enclosures: [ ] Denial letter [ ] Letter of medical necessity [ ] Chart notes [ ] Lab results [ ] Prior-treatment records

Sincerely,
[Your Name]
[Signature]

This is a general, editable template for personal use - not legal or medical advice, and not a guarantee of coverage. Appeal rules, required forms, deadlines, and outcomes vary by plan and by state. Check your denial letter and plan documents for your appeal deadline (often 30 to 180 days) and exact requirements, and ask your prescriber to complete the letter of medical necessity.

Source: glp1clinics.org/insurance/appeals