

Note to physician: This template may be used to create your own institution's independent letter of appeal to be sent to a patient's health plan in the event that there is a denial of coverage for JELMYTO® (mitomycin) for pyelocalyceal solution.

RE: Letter of Appeal for JELMYTO® (mitomycin) for pyelocalyceal solution

Patient Name: [Patient Name]

Patient DOB: [mm/dd/yyyy]

Date of Service: [mm/dd/yyyy]

Denied Item: [enter item (Example: J3490)]

Reason for Denial: [enter denial reason. (Example: medical necessity)]

Patient Insurance ID: [Patient ID]

Provider ID: [Provider ID]

Dear [Medical / Appeals Reviewer or Medical Director],

Please accept this letter as a formal request to appeal the denied claim for JELMYTO® (mitomycin) for pyelocalyceal solution for my patient [insert patient name] for dates of service [insert dates of service]. It is my understanding that coverage has been denied because [insert specific denial reason]. Please see the enclosed documentation that discusses [insert patient name] medical history and supporting information in more detail.

[Provide specific information regarding medical history, prognosis, and medical rationale for selecting JELMYTO.]

[If applicable, provide specific information regarding the treatments this patient has already received.]

[Provide specific information regarding the patient's current state of health and why JELMYTO is the most appropriate treatment option.]

I appreciate your prompt review and consideration to reverse your previous decision concerning coverage of JELMYTO for [insert patient name].

Please contact me at [XXX-XXX-XXXX] or [Physician Email] if I can provide any further information.

Sincerely,

[Physician Name]

[Physician Signature]