**SoftWave Pre-Authorization Denial Appeal**

[SITE LETTERHEAD]

[DATE]

[NAME OF INSURANCE COMPANY] [ATTN:]

[FAX#:]

Regarding: [PRIMARY CPT CODE:]

[INSURANCE IDENTIFICATION NUMBER]

[REFERENCE #:]

[PRIMARY CPT CODE:]

[PRIMARY DX CODE:]

Dear Utilization Review Manager:

Please accept this letter on behalf of [PATIENT NAME], as an appeal to [INSURANCE COMPANY]’s decision to deny coverage for the recommended [PROCEDURE]. It is my understanding, per [INSURANCE COMPANY]’s   
denial letter dated [INSERT DENIAL LETTER DATE], that this procedure has been denied because [REASON   
FOR DENIAL].

I respectfully request that [INSURANCE COMPANY] reconsider its denial and provide authorization for this treatment option. I believe this denial was made in error. This letter and its supporting documents will provide

you with a better depiction of this patient’s clinical history and this patient’s need for [SoftWave Treament]

Description of Procedure: [PHYSICIAN MAY INSERT DETAILED PROCEDURE DESCRIPTION FOR SPECIFIC   
TECHNOLOGY/ ANATOMY INCLUDING THE USE OF [SoftWave Treatment, CHOOSE ONE BELOW]

SoftWave is a non-invasive, extracorporeal shock wave procedure using patented technology to initiate the body’s immune system. It has FDA clearance for the treatment of superficial, partial-thickness, second-degree burns in adults and for the treatment of Diabetic Foot Ulcers (DFU’s).

Relevant Clinical Evidence for Procedure Modality: [PHYSICIAN MAY INSERT RELEVANT CLINICAL EVIDENCE FOR SPECIFIC TECHNOLOGY/ANATOMY, CHOOSE FROM OPTIONS ON PAGE BELOW].

Patient’s Clinical Need for SoftWave Procedure: [PATIENT NAME] is a [AGE] [GENDER] who presented to me with [DESCRIBE SYMPTOMS WITH SPECIFICITY]. Prior treatments have included [DESCRIBE CONSERVATIVE CARE, USE OF MEDICATIONS, PRIOR TREATMENTS, and PHYSICAL AIDS].

To assist in your reconsideration of this patient’s clinical need for the intended procedure, a copy of the

relevant clinical notes that support use of [SoftWave] is enclosed to support you with your decision to   
overturn your initial denial of coverage for these services. It is my sincere hope that [INSURANCE COMPANY] will respond with a positive decision so that [PATIENT NAME] can benefit from the results of this procedure. Should you have further questions or concerns, please do not hesitate to call me at [INSERT PHYSICIAN   
TELEPHONE NUMBER]. Thank you for your immediate attention and reconsideration.

Sincerely,

[PHYSICIAN NAME], [DEGREE]

[PRACTICE NAME]