

[Patient's Full Name]
[Address]
[City, State, ZIP]
[Phone Number]
[Email Address]

[Insert Date]

To: [Medical Director or Appeals Department]
[Insurance Company Name]
[Insurance Company Address]
[City, State, ZIP]

Re: Appeal of Denial - Personal Impact Statement
Patient: [Full Name]
DOB: [MM/DD/YYYY]
Insurance ID: [Insert Number]
Diagnosis: Neuromyelitis optica spectrum disorder (NMOSD), ICD-10 G36.0
Prescribed Medication: [Insert Medication Name]

To Whom It May Concern,

My name is [Patient's Full Name], and I am writing this letter as part of my formal appeal regarding the denial of coverage for the treatment my neurologist has prescribed to manage my neuromyelitis optica spectrum disorder (NMOSD), a life-altering and potentially life-threatening disease I live with every day.

NMOSD is not just a diagnosis; it is a condition that has already taken a significant toll on my health, independence and overall quality of life. I have suffered from [briefly describe symptoms or episodes - e.g., sudden loss of vision in one eye, severe weakness or spinal cord inflammation], which have left me terrified of what each new day might bring. Every relapse leaves damage that may never heal. The last attack I experienced left me with [insert lasting effects if applicable, such as partial paralysis, vision loss, bladder/bowel dysfunction, chronic pain or fatigue]. The physical consequences are devastating, but the emotional and psychological toll is just as profound.

I am fully aware that there is no cure for NMOSD, but there are treatments that can help prevent relapses and allow me to live a life with some stability and hope. The medication my neurologist prescribed is not experimental or optional; it is FDA-approved and recognized by specialists worldwide as one of the few proven therapies that can prevent irreversible damage and death in patients like me.

To have this medication denied by my insurance is devastating. It feels like my life is being weighed against a spreadsheet, and the conclusion is that it's not worth the cost. But I am more than a number. I am a [insert personal details, e.g., mother, father, student, worker, spouse, caregiver, etc.], and I want nothing more than to maintain my ability to [insert specific goals or responsibilities - e.g., take care of my children, continue working, live independently, contribute to my community].

Every day without this medication puts me at serious risk of another attack. I live with the constant fear that the next relapse could leave me blind, unable to walk, or worse. That fear affects every decision I make. I am not asking for something extraordinary - I am asking for the treatment my doctor says I need to survive.

I urge you to reconsider the denial of this medication. This is not just about medical necessity; it is about preserving my dignity, my independence and my life. Please don't let bureaucracy decide my fate when science and my physician have already provided a clear, evidence-based path forward.

Thank you for taking the time to read my story and for your thoughtful reconsideration of my appeal.

Sincerely,
[Signature]
[Patient's Full Name]