Sample Appeal Letter: Client is Not Able to Use this Device Independently

(DATE)

(INSURANCE NAME)
(INSURANCE ADDRESS)
(INSURANCE CITY, STATE ZIP)

RE: (FULL NAME OF CLIENT)
DOB: (DATE OF BIRTH)

To whom it may concern:

I recently submitted a request for purchase of the (DEVICE NAME) for my client, (CLIENT's NAME), who has a medical diagnosis of (DIAGNOSIS) and a speech-language diagnosis of (DIAGNOSIS). These diagnoses have left (HIM/HER) functionally nonverbal and unable to adequately express (HIS/HER) medical needs in an effective way without the use of Augmentative-Alternative Communication (AAC). As outlined in the AAC Evaluation Reported dated (DATE OF YOUR ORIGINAL REPORT), it is medically necessary for (CLIENT) to have access to a speech-generating device (SGD) so that (HIS/HER) medical needs can be expressed and met. (DOCTOR's NAME) was in agreement with my recommendation for purchase of the (DEVICE NAME) as the most cost-effective solution for meeting (CLIENT's) current medical communication needs.

On (DATE), I received notice that the E2510 (DEVICE NAME) was denied due to the following explanation:

*(*INSERT THE WORDING TO MATCH WHAT WAS SAID IN YOUR DENIAL DOCUMENT)*

I am appealing this decision based on the following information:

- *(Provide examples of how the client has demonstrated independent use of the device. Use a chart if possible so that all of your points are clearly illustrated. Below is a sample of what you might include. Your chart should show an increase toward independent use of the device over time. Discuss the data (trends towards independent communication) in narrative form below the chart. If you cannot make a chart, use as many examples as you can in a narrative showing trends toward independent use and learning/memory for symbols and construction of messages.)*

| DATE | TASK or ACTIVITIY | UTTERANCE | PROMPTING REQUIRED |
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If further information is needed to substantiate this request, please contact me. Thank you for your time.

Sincerely,


(YOUR NAME AND CREDENTIALS)
(TITLE)
(EMPLOYER NAME)
(EMPLOYER ADDRESS)
(EMPLOYER CITY, STATE, ZIP)

(PHONE)
(FAX)
(EMAIL)