

Dear Medical Director/Medical Review Officer:

My name is **(insert name)** and I am responding to your letter dated **(Insert Date)** for denial of coverage for Intacs for Keratoconus, and I am requesting an appeal. I have keratoconus -- a degenerative eye disease for which there is no known cause or cure. This disease causes a thinning to my cornea leading to a bulge or cone-like shape due to normal eye pressure. These changes and stresses in the cornea cause significant and debilitating visual impairment, making the simplest things in life difficult to do.

My doctor, **(insert Doctor's name)** requested authorization to proceed with Intacs implantation to help strengthen and restore my cornea so that my eyesight can be improved. You have denied authorization, and stated in your attached letter that (select one:)

- **This is an experimental/investigational procedure**
- **This is not the standard of care for my condition**
- **This is not medically necessary for my condition**
- **This is a refractive procedure and not a covered benefit.**

(I have attached a copy of your letter.)

I believe that information about Intacs for Keratoconus shows that insurance coverage and reimbursement are both appropriate and necessary. Successful Intacs implantation could mean that I would be able to lead a normal life as a result of regaining my ability to see. I'm asking you to reconsider your decision immediately.

To date, my keratoconus condition cannot be successfully managed with glasses or contact lenses, for which I am intolerant, and a corneal transplant is not currently recommended by my doctor.

*(Personalize the letter, using the information outline that follows. You may need one or more paragraphs for each of the headings listed.)*

- *Talk about your keratoconus, and how long you have suffered from it.*
- *Talk about the effects of keratoconus for you.*
- *Talk about the specific limitations you experience as a result of your condition, such as the physical and emotional effects.*
- *Discuss the debilitating challenged you face in your daily life with limited and significantly impaired sight, and how this has affected your quality of life.*
- *Write about other therapies you have tried and include the results. Point out other options you may have considered and why they are not acceptable (such as contact lens intolerance and avoidance of a corneal transplant.)*

My doctor believes that given the treatment methods available, Intacs for Keratoconus is the most appropriate choice. He will provide you with additional information and clinical literature for your review.

I am very hopeful treatment with Intacs will help me lead a more normal life. Please reconsider your denial and allow me to have the Intacs for Keratoconus procedure done in order to improve my quality of life. I will contact you on **(insert date)**, to learn what else must be done to reverse your decision. At that time I also expect to learn more about your appeal process and the next steps to take.

Sincerely,

**(Insert name)**

**(Insert phone number)**

NOTE:

Provide your doctor the example pre-determination letters and/or appeal letters so they can enter the appropriate clinical information in to describe your condition. Attach these to this letter if applicable.