[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department Address]
[City, State, ZIP Code]
Subject: Appeal for Denied Disability Benefits for [Your Full Name or Claim Number]
Dear [Claims Officer's Name or Insurance Company],
I am writing to formally appeal the denial of my disability benefits, as communicated in your letter dated [Denial Date]. While I understand the decision was based on [briefly state reason in denial letter], I believe this decision was made without the full consideration of my medical condition and its impact on my ability to work.
As outlined in the documentation attached, my medical condition, [specific condition], has been thoroughly assessed by my healthcare providers, and significantly limits my ability to perform essential work-related duties. The enclosed medical records, functional capacity evaluations, and professional assessments clearly illustrate the severity of my situation.
It is crucial to acknowledge that [specific point from your medical documentation], which directly affects my daily functions and work capacity. The Social Security guidelines and my healthcare team's expertise unanimously indicate my eligibility for these benefits due to my inability to engage in substantial gainful activity.
I request a reconsideration of my application based on the merit of the provided evidence. I am confident that a thorough review will recognize the legitimacy of my claim and the necessity for support.
Thank you for reassessing my case. I am available for further discussion and willing to provide any additional information needed to conclude this matter justly.
Sincerely,
[Your Name]
[Attachments: Medical Records, Additional Documentation, etc.]