**[Physician Letterhead]**

Attn: [Medical Director] RE: [Patient Name]

 [Insurance company] [Date of Birth]

 [Address] [Policy Number]

 [City, State, ZIP code] [Claim Number]

Reference Number: [Reference Number]

Product: i-FACTOR®

Submission Date: [Submission Date]

Denial Date: [Denial Date]

To whom it may concern,

On behalf of [Patient Name], I am writing to you to request that you reassess your recent denial coverage for i-FACTOR® with the intended use for anterior cervical discectomy and fusion (ACDF). It is my understanding based on a letter of denial that i-FACTOR® has been denied because [Quote the specific reason for the denial stated in the denial letter] on [date of denial].

I believe [Patient Name] would benefit from i-FACTOR® in the ACDF surgery. Please see the enclosed documentation that discuss [Patient Name]’s medical history and supporting information in detail.

**The following items are enclosed**

* [Medical literature regarding the use of i-FACTOR® in ACDF]
* [Relevant clinical documentation, such as patient diagnosis, radiographic results, previous treatment and results, and Letter of Medical Necessity]
* [Applicable coverage policies]

The enclosed information supports the claim that treatment is medically necessary. I strongly believe this request should be covered and request that you reconsider coverage based on the evidence provided. Due to the acute nature of this disease, I would appreciate your prompt review of this appeal.

If you have any further questions regarding this matter or need additional information, please contact my office at [Phone Number].

Sincerely,

[Insert physician name and participating provider number]

Enclosures

**Important Information:**

The information contained in this template letter is provided by Cerapedics for informational purposes for patients who have been treated with i-FACTOR® and does not constitute reimbursement or legal advice. Clinical information provided to any federal, state or commercial payor must be supported by documentation in the patient’s medical record.

Cerapedics does not promise or guarantee coverage, payment, or rate of payment for i-FACTOR in anterior cervical discectomy and fusion (ACDF) or any other services or line items billed in conjunction with the use of i-FACTOR in ACDF. The provider accepts full risk for reimbursement pertaining to the foregoing for each patient.  It is always the responsibility of the provider to accurately document patient clinical condition and to appropriately select and report patient diagnosis as well as services delivered. The provider is responsible for the accuracy of all communications with payors including, but not limited to, the information submitted in relation to this document. The provider is responsible for determining medical necessity and the proper site for use of i-FACTOR in ACDF, and for submitting appropriate codes, charges, and modifiers for services rendered.

There is no requirement that any patient or healthcare provider uses i-FACTOR in exchange for this information. Use of the information in this letter does not guarantee that the health plan will provide reimbursement for -FACTOR in ACDF and this information not intended to be a substitute for, or an influence on, the independent medical judgment of the physician.  All reimbursement and health economic information provided by Cerapedics is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies.

For additional questions or assistance on approval of i-FACTOR, please contact **reimbursement@cerapedics.com**ML-0769 01.17.23 ©2023 Cerapedics Inc.