Physician's Letterhead

Date of Appeal

Insurance Carrier Name
Insurance Carrier Address
Attention Line: Claims Appeals

Reference:	***Additional Information, based on carrier preference and appeal rationale***
Claim Number:	Date of Claim Determination:
Patient Name:	Patient Date of Birth (DOB):
Patient Identification Number:	Subscriber's Name, if different than patient:
Date of Service (DOS):	Place of Service (POS):
Provider's Name:	ICD-9 Code(s):
Provider's Identifier, NPI, Tax ID, Insurance Provider Number:	Amount Billed: Amount in Dispute:

Dear Claims Review Department:

I am writing to appeal denial of procedure code(s) _____. According to (Insurance Representative's Name) on (Date of Phone Call), this claim was denied because_____.

List the supporting documentation that is included to substantiate the facts. A bulleted, easily readable format is best. Summarize why the enclosed documentation supports payment of the claim.

Indicate the action you are requesting, such as reprocessing of the claim or increased payment. Conclude by thanking the representative for his or her time, and offering your contact information in the event that clarification or additional documentation is required.

Sincerely,

Billing Representative
Title

Enclosures: *List the specific enclosures that are accompanying the appeal*