

[Your Name/Organization Name]  
[Address]  
[City, State, Zip Code]  
[Phone Number]  
[Date]

[Payer Name]  
[Appeals Department Address]  
[City, State, Zip Code]

**RE: Appeal for Chronic Care Management (CCM) Services**

**Patient Name:** [Patient Name]  
**Policy Number:** [Policy Number]  
**Group Number:** [Group Number]  
**Claim Number:** [Claim Number]  
**Date of Service:** [Date of Service]  
**CPT Code(s):** [e.g., 99490, 99439, 99487]

To Whom It May Concern:

This letter is a formal appeal regarding the denial of the above-referenced claim for Chronic Care Management (CCM) services. The claim was denied based on a perceived "lack of medical necessity." We strongly disagree with this determination.

The patient meets all clinical requirements for CCM services as defined by CMS and industry standards:

- **Multiple Chronic Conditions:** The patient has been diagnosed with at least two chronic conditions expected to last at least 12 months, or until the end of life. These include: [List Conditions, e.g., Diabetes, Hypertension].
- **Significant Risk:** These conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- **Comprehensive Care Plan:** A comprehensive care plan has been established, implemented, revised, and monitored for this patient.

During the month of service, our clinical staff provided [Number] minutes of non-face-to-face care coordination. This time was spent on [Briefly list activities, e.g., medication reconciliation, communication with specialists, and monitoring treatment adherence]. These services are vital to preventing emergency department visits and hospitalizations for this high-risk patient.

Attached you will find the patient's clinical documentation, including the established care plan and the time logs for the period in question, which support the medical necessity of these services.

We request that you overturn this denial and process the claim for payment. Should you require additional information, please contact [Contact Name] at [Phone Number].

Sincerely,

[Signature]

[Printed Name and Title]

[Practice Name]

**Enclosures:** Patient Care Plan, Clinical Encounter Notes, CCM Time Logs.