

[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Appeal for Claim #[Claim Number]

Member Name: [Patient Name]

Member ID: [ID Number]

Date of Service: [Date]

To the Appeals Committee,

I am writing to formally appeal the denial of coverage for services provided by [Provider Name] on [Date]. My claim was denied/partially paid on the basis that the provider is outside of the preferred network.

I am requesting that this claim be processed at the in-network rate for the following reason(s):

- **[Option 1: Emergency Care]** These services were received during a medical emergency, and I was unable to choose a provider within the network.
- **[Option 2: Network Inadequacy]** There are no in-network providers within a reasonable distance who possess the necessary expertise to treat my specific condition.
- **[Option 3: No Choice/Surprise Billing]** While the facility was in-network, the specific provider assigned to me was out-of-network without my prior knowledge or consent.

Attached you will find supporting documentation, including [Medical Records / Referrals / Evidence of Network Gaps].

I request a review of this claim and a written response regarding your decision within [Number] days. Thank you for your time and consideration of this appeal.

Sincerely,

[Your Signature]
[Your Printed Name]