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

[Date]

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

RE: Formal Appeal for Claim #[Claim Number]
Member Name: [Patient Name]
Member ID Number: [ID Number]
Group Number: [Group Number]
Date of Service: [Date]

To Whom It May Concern,

I am writing to formally appeal your decision to deny coverage (or provide partial reimbursement) for services provided by [Provider Name] on [Date]. Your Explanation of Benefits (EOB) dated [Date] states that these services were processed at the out-of-network rate.

I am requesting that this claim be reprocessed at the in-network benefit level for the following reason(s):

- [Insert reason: e.g., No in-network providers were available within a reasonable distance for this specialty.]
- [Insert reason: e.g., This was an emergency medical situation requiring immediate care at the nearest facility.]
- [Insert reason: e.g., I received prior authorization for this out-of-network referral.]
- [Insert reason: e.g., I was treated by an out-of-network provider at an in-network facility without my consent.]

Attached please find supporting documentation, including [list documents, e.g., medical records, a letter of medical necessity from my primary doctor, or the prior authorization approval].

Please review this claim again to ensure I am receiving the maximum benefit under my plan. I look forward to your written response within the timeframe required by law.

Sincerely,

[Your Signature]
[Your Printed Name]