

[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

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

RE: Appeal for Claim #[Claim Number]

Patient Name: [Patient Name]

Member ID: [Member ID Number]

Date of Service: [Date of Emergency]

Provider: [Clinic/Facility Name]

To Whom It May Concern:

I am writing to formally appeal the denial of coverage (or the out-of-network processing) for the emergency medical services received at [Clinic Name] on [Date].

The services provided were for a medical emergency. At the time of the incident, I experienced [Briefly describe symptoms, e.g., severe chest pain, sudden injury, shortness of breath]. Due to the acute nature of these symptoms, I reasonably believed that any delay in seeking care would seriously jeopardize my health.

Under the "Prudent Layperson" standard and the No Surprises Act, emergency services should be covered at the in-network rate regardless of the provider's network status. Because this was an emergency situation, I was unable to choose an in-network facility or verify the network status of the providers during the crisis.

I have attached the following documents to support this appeal:

- A copy of the Explanation of Benefits (EOB)
- Medical records/discharge summary describing the emergency condition
- [Any other supporting documents]

I request that you review this claim and adjust the payment to reflect in-network cost-sharing levels. Please notify me of your decision within the timeframe required by law.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]