

[Date]

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

RE: Authorized Representative Appeal for Out-of-Network Services

Patient Name: [Patient Name]
Member ID Number: [ID Number]
Claim Number: [Claim Number]
Date of Service: [Date]
Provider/Clinic Name: [Clinic Name]

To Whom It May Concern,

This letter serves as a formal appeal regarding the denial of coverage or out-of-network processing for services provided to the above-mentioned patient. [Clinic Name] is acting as the patient's Authorized Representative for this appeal. A signed Authorization Form is attached to this letter.

We are requesting that these services be covered at the in-network benefit level for the following reason(s):

- **[Option 1: Network Inadequacy]** There were no available in-network providers with the necessary expertise to treat the patient's specific condition within a reasonable geographic distance.
- **[Option 2: Emergency Services]** The services rendered were for an emergency medical condition, which must be covered at the in-network rate under the No Surprises Act.
- **[Option 3: Continuity of Care]** The patient was undergoing an active course of treatment when their previous provider left the network.
- **[Option 4: Prior Authorization]** A prior authorization was obtained (Reference #[Number]), and we were led to believe the services would be covered.

Enclosed are medical records and supporting documentation that justify the medical necessity of the treatment and the requirement for it to be performed at our facility. The current out-of-network designation places an undue financial burden on the patient for essential medical care.

We request a full review of this claim and a timely written response regarding your decision. Please reprocess this claim at the in-network level of benefits.

Thank you for your immediate attention to this matter.

Sincerely,

[Signature]

[Name of Representative]

[Title]

[Clinic Name]

[Phone Number]

Enclosures: Signed Authorization Form, Medical Records, Copy of Original Denial/EOB.