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

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

RE: Appeal for Timely Filing Limit Exceeded
Patient Name: [Patient Name]
Member ID: [Subscriber ID]
Group Number: [Group Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Billed Amount: $[Amount]

To Whom It May Concern,

This letter is a formal appeal regarding the denial of the above-referenced claim due to timely filing limits. We are requesting an exception to the filing deadline because the delay was caused by a Coordination of Benefits (COB) issue.

The claim was originally submitted to the primary carrier, [Primary Insurance Name], on [Date]. We received an Explanation of Benefits (EOB) from them on [Date] indicating that [reason for primary delay or denial, e.g., they were secondary / requested COB update from member].

Upon receiving the necessary information and the primary EOB, we submitted the claim to your organization immediately. As the delay was outside of our control and contingent upon the primary payer's processing time, we respectfully request that you waive the timely filing limit and process this claim for payment.

Enclosed please find the following supporting documentation:

- A copy of the original claim.
- The Explanation of Benefits (EOB) from the primary carrier.
- Correspondence logs regarding COB verification.

Thank you for your time and reconsideration of this claim. If you require additional information, please contact me at [Phone Number].

Sincerely,

[Signature]
[Printed Name/Title]