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

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

RE: Appeal for Denied Claim
Patient Name: [Patient Full Name]
Patient ID/Policy Number: [Member ID]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Total Amount Denied: [Amount]

To Whom It May Concern,

This letter is a formal appeal regarding the denial of the above-referenced claim. The claim was denied for missing or invalid anatomical laterality modifiers.

Upon review of the medical documentation, it has been confirmed that the procedure was performed on the [Left / Right / Bilateral] side of the patient's body. Please find the corrected billing information below:

- **Procedure Code:** [CPT/HCPCS Code]
- **Corrected Modifier:** [Insert LT, RT, or 50]

Attached to this letter is the operative report and/or clinical documentation supporting the specific laterality of the procedure. We request that you reprocess this claim with the updated modifier information to reflect the services rendered accurately.

Thank you for your prompt attention to this matter. If you require further information, please contact [Name] at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Credential]

Enclosures:
- Copy of Original Denial/EOB

- Medical Records/Operative Report
- Corrected CMS-1500 Form (if applicable)