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

[Date]

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

RE: Coordination of Benefits Appeal
Member Name: [Member Name]
Member ID Number: [ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

Dear Appeals Department,

I am writing to formally appeal the denial of the above-referenced claim. The claim was denied or pended based on a request for Coordination of Benefits (COB) information or an incorrect designation of the primary insurer.

I am providing the following information to update your records and ensure correct processing of this claim:

Primary Insurance Information:
Carrier Name: [Carrier Name]
Policy Number: [Policy Number]
Effective Date: [Date]

Secondary Insurance Information:
Carrier Name: [Carrier Name]
Policy Number: [Policy Number]
Effective Date: [Date]

According to the "Birthday Rule" or specific plan provisions (e.g., [Employer Name] group coverage vs. individual coverage), [Insurance Company Name] is the [Primary/Secondary] payer for this member.

Attached you will find [List attachments, e.g., a copy of the front/back of the insurance cards, the Explanation of Benefits (EOB) from the other carrier, or a letter from the other insurer confirming coverage status].

Please update my file and reprocess this claim immediately. If you require further information, please contact me at [Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]