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

[Date]

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

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

To Whom It May Concern,

I am writing to formally appeal the denial of the above-referenced claim based on a Coordination of Benefits (COB) discrepancy. The claim was denied under the assumption that another insurance provider is primary; however, there has been a retroactive change in coverage status that needs to be updated in your records.

Please find the following details regarding the coverage update:

- **Primary Insurer:** [Name of Insurance Company]
- **Policy Number:** [Policy Number]
- **Effective Date of Retroactive Change:** [Date]
- **Reason for Update:** [Briefly state reason, e.g., loss of previous primary coverage, change in employment, or corrected termination date]

Attached is the Letter of Creditable Coverage (LOCC) and documentation from [Other Insurance Company Name] confirming the retroactive termination or secondary status of that policy. Based on this information, [Current Insurance Company Name] is the correct primary payer for the date of service mentioned above.

I request that you update my COB profile immediately and reprocess this claim for payment. Please provide a written confirmation once the records have been corrected and the claim has been adjusted.

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

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List attached documents, e.g., Termination Letter, Coverage History, EOBs]