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

To the Appeals Department,

I am writing to formally appeal the denial of the above-referenced claim for outpatient services provided at [Clinic Name]. The claim was denied based on a Coordination of Benefits (COB) issue; however, I believe this denial is in error.

I would like to clarify my insurance coverage status as follows:

- [Option A: This insurance is my primary and only coverage. I have no other active health insurance policies.]
- [Option B: This insurance is my primary coverage. My secondary insurance is (Other Company Name), Policy (Number).]
- [Option C: This insurance is my secondary coverage. My primary insurance is (Other Company Name), Policy (Number).]

Attached to this letter, please find [mention any documents, such as a Letter of Creditable Coverage, termination notice from a previous insurer, or a completed COB questionnaire].

Please update my records to reflect this information and reprocess the claim for payment immediately. If you require any further information to resolve this matter, please contact me at [Your Phone Number].

Thank you for your prompt attention to this appeal.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List attached documents]