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

[Date]

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

**RE: Appeal of Claim Denial / Coordination of Benefits**
Patient Name: [Newborn's Name]
Date of Birth: [Newborn's Date of Birth]
Member ID: [Your Member ID Number]
Claim Number: [Claim Number(s)]
Date of Service: [Date of Hospital Stay/Services]

To the Appeals Department,

I am writing to formally appeal the denial of claims related to the care of my newborn child, [Newborn's Name]. The claims were denied or delayed due to a request for Coordination of Benefits (COB) information or a dispute regarding primary coverage.

Please be advised of the following coverage details:

**Primary Insurance:** [Name of Primary Insurance Company]
Policy Holder: [Name]
Policy/Group Number: [Number]

**Secondary Insurance (if applicable):** [Name of Secondary Insurance Company]
Policy Holder: [Name]
Policy/Group Number: [Number]

Under the "Birthday Rule" or applicable state regulations, [Name of Parent] whose birthday falls earlier in the calendar year is the primary policyholder for the dependent. According to these guidelines, [Insurance Company Name] should be the [Primary/Secondary] payer for these services.

I have attached the following supporting documents:
- Copies of insurance cards for both parents
- Explanation of Benefits (EOB) from the other carrier (if applicable)
- Hospital discharge summary for the newborn

I request that you update your records regarding Coordination of Benefits and reprocess the denied claims immediately. Please provide a written response regarding the status of this appeal within [15/30] days.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]