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

[Date]

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

RE: Appeal of Coordination of Benefits Discrepancy
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]
Policy Number: [Policy Number]

To Whom It May Concern,

I am writing to formally appeal the recent determination regarding the Coordination of Benefits (COB) for my Workers' Compensation claim. I received notice on [Date of Notice] stating that there is a discrepancy in how benefits are being allocated between [Name of Workers' Comp Carrier] and [Name of Health Insurance Carrier].

I disagree with the current assessment for the following reasons:

- [Reason 1: e.g., The injury is strictly work-related and should be covered 100% by Workers' Compensation.]
- [Reason 2: e.g., The health insurance plan has been incorrectly identified as the primary payer.]
- [Reason 3: e.g., There is a mathematical error in the offset calculation.]

Attached are the following documents to support my appeal:

- [Document 1: e.g., Medical reports confirming work-relatedness]
- [Document 2: e.g., Explanation of Benefits from my private health insurer]
- [Document 3: e.g., Previous correspondence regarding claim approval]

Please review my file and the attached documentation to correct this discrepancy. I request that my benefits be adjusted to reflect the accurate primary coverage and that any withheld payments be issued immediately.

I look forward to your written response within [Number of Days, e.g., 15] business days. If you require further information, please contact me at [Your Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]