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

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

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

To Whom It May Concern,

I am writing to formally appeal the denial of the above-referenced claim. The claim was denied stating that updated Coordination of Benefits (COB) information is required or that another insurer is primary.

Please be advised that my insurance coverage information has been updated. I am providing the following details to ensure your records are current:

- **Primary Insurance:** [Insurance Company Name] / [Policy Number]
- **Secondary Insurance (if applicable):** [Insurance Company Name] / [Policy Number]
- **Effective Date of Change:** [Date]

I have confirmed that [Your Insurance Company Name] is the primary payer for this service because [Reason: e.g., this is my employer-sponsored plan / the other plan has been terminated]. Attached, please find a copy of [Document: e.g., my insurance card / termination letter from previous carrier].

Based on this updated information, I request that you reprocess the claim for payment. If any further information is required to resolve this matter, please contact me directly at [Your Phone Number].

Thank you for your prompt attention to this appeal.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List attached documents, e.g., Copy of Insurance Card, Letter of Creditable Coverage]