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

[Date]

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

RE: Coordination of Benefits (COB) Discrepancy

Member Name: [Your Name / Dependent Name]
Primary Policy Number: [Primary ID Number]
Secondary Policy Number: [Secondary ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Visit]

To Whom It May Concern,

I am writing to formally request a review of the claim mentioned above regarding a routine visit. It appears there is a discrepancy in how the Coordination of Benefits (COB) was applied between my primary and secondary insurance providers.

According to my records, the primary insurance ([Primary Company Name]) processed the claim on [Date]. The remaining balance was then submitted to you, the secondary insurer. However, the claim was [denied / partially paid] due to [reason stated on EOB, e.g., "COB information requested" or "Incorrect primary payment amount"].

Please find the following documents attached for your review:

- Explanation of Benefits (EOB) from the primary insurer.
- A copy of the itemized bill from the provider.
- Completed COB Questionnaire (if required).

I confirm that [Primary Insurance Name] is my primary coverage and [Secondary Insurance Name] is my secondary coverage. Please update your records to reflect this coordination and reprocess the claim to cover the remaining balance as per my policy benefits.

Thank you for your prompt attention to this matter. Please notify me in writing once the claim has been reprocessed.

Sincerely,

[Your Signature]
[Your Printed Name]