[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Tax ID / NPI Number]

[Date]

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

RE: Appeal of Payment Recoupment / Refund Request

Patient Name: [Patient Name]
Member ID: [Member ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Recoupment Amount: $[Amount]

Dear Appeals Committee,

This letter is a formal appeal regarding the recoupment request/denial dated [Date of Recoupment Notice] for the above-referenced claim. The recoupment was initiated based on a Coordination of Benefits (COB) discrepancy.

We have reviewed our records and verified the following information regarding the patient's coverage at the time of service:

- **Primary Insurance:** [Name of Primary Plan]
- **Secondary Insurance:** [Name of Secondary Plan]
- **Verification Method:** [e.g., Patient Attestation / Phone Verification / Electronic Eligibility Search]

Based on the "Birthday Rule" or established COB guidelines, [Insurance Company Name] is the correct [Primary/Secondary] payer for this patient. Attached, please find [Supporting Documents: e.g., Explanation of Benefits from other carrier, Coordination of Benefits form signed by patient, or Eligibility Screen Printout] which confirms the order of benefits.

We request that you reverse the recoupment and maintain the original payment. If the recoupment has already been processed via an offset from a more recent remittance advice, we request an immediate refund/reprocessing of this claim.

Please review this appeal and provide a written response within [Number, e.g., 30] days. Should you require further information, please contact our billing department at [Phone Number].

Sincerely,

[Signature]
[Name of Billing Manager/Provider]
[Title]

Enclosures: [List documents attached]