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

[Date]

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

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

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for the specialist referral services provided on [Date of Service]. My records indicate that the claim was denied due to a Coordination of Benefits (COB) discrepancy or a request for updated primary insurance information.

I would like to clarify that [Insurance Company Name] is my **[Primary/Secondary]** insurance provider. My insurance hierarchy is as follows:

- **Primary Insurance:** [Company Name] | Policy #: [Policy Number]
- **Secondary Insurance:** [Company Name] | Policy #: [Policy Number]

I have verified this information with all parties involved. The referral provided by my Primary Care Physician (PCP) was active at the time of the appointment, and all necessary authorizations were obtained according to policy guidelines.

Attached to this letter, please find:

- A copy of the Explanation of Benefits (EOB) from my primary insurer (if applicable).
- A copy of the specialist referral form.
- Verification of current insurance status.

I request that you update your records and re-process this claim immediately to reflect the correct coordination of benefits. Please notify me in writing of the outcome of this appeal within [Number] days.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]