[Your Name/Organization Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Appeal of Denial for Bundled Outpatient Services
Patient Name: [Patient First and Last Name]
Member ID: [Member ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Total Amount Disputed: [Dollar Amount]

To Whom It May Concern,

This letter serves as a formal appeal for the reconsideration of the denial of the following CPT/HCPCS codes: [List Codes], which were denied as "bundled" or "incidental" to the primary procedure [List Primary Code].

We contend that these services should be reimbursed separately based on the clinical evidence and medical necessity outlined below. The services performed were distinct, required additional effort, and were not integral components of the primary procedure.

Clinical Justification:

- **Distinct Procedural Service:** [Provide a brief clinical explanation of why the service was separate, e.g., performed on a different site, via a separate incision, or during a different session].
- **Medical Necessity:** [Briefly describe the patient's specific condition or complications that required the additional service].
- **Coding Guidelines:** According to [mention specific guidelines, e.g., NCCI Edits or CPT Instructions], the use of modifier [e.g., -59, -XU, or -25] is appropriate in this clinical scenario to represent a separate and distinct service.

Supporting Documentation Attached:

- Operative Report / Procedure Notes
- Physician's Orders
- Relevant Clinical Pathology or Imaging Reports
- Copy of the Original Remittance Advice

We request that you re-evaluate this claim in light of the provided clinical evidence. Please process this appeal within the standard timeframe and notify us of your decision in writing.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Printed Name]
[Title/Credentials]